2006 POLICY

Benefits for Plan Year Beginning July 1, 2005

Offering individual health insurance coverage to West Virginians who have pre-existing, severe or chronic medical conditions.

AccessWV

P.O. Box 50540, Charleston, WV 25305-0540

AccessWV0011; 0805

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www.AccessWV.org

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Welcome to AccessWV!

This booklet describes the benefits available to AccessWV members for the plan year beginning July 1, 2005.

This Policy is your contract as a member of AccessWV. It describes all of the benefits covered under AccessWV, how to use them, and where to write or call when you have questions or concerns. Please keep it close at hand and refer to it often as you have questions about your AccessWV benefits.

This Policy provides AccessWV members with an easy-to-read description of benefits available through AccessWV, and instructions on how to use these benefits. AccessWV contracts with the Public Employees Insurance Agency (PEIA) which subcontracts with third party administrators (TPAs), Acordia National and Express Scripts, Inc. to process health and drug benefit claims. If you have a question about a specific claim or benefit, the fastest way to obtain information is to contact the appropriate TPA directly at one of the phone numbers listed on page 2.

AccessWV plans include benefits for hospital, surgical, prescription drug, and other medical expenses. Monthly premiums for AccessWV are based on the age and gender of the applicant, the geographic area where the applicant resides, whether the policyholder chooses single or family coverage and deductible amounts and out-of-pocket maximums for medical benefits and prescription drug benefits. To determine the deductible amount and out-of-pocket maximums, refer to the Summary of Benefits section of this policy.

WHERE TO CALL WITH QUESTIONS

Health Claims, Benefits, and Preauthorizations
Acordia National:
1-866-864-6142 (toll-free) or on the web at www.acordianational.com

Precertification and Utilization Management
Acordia National:
1-866-864-6142 (toll-free) or on the web at www.acordianational.com

Prescription Drug Benefits and Claims
Express Scripts: 1-877-256-4680 (toll-free)
or on the web at www.express-scripts.com

Subrogation and Recovery
Beacon Recovery Group: 1-800-874-0500 (toll-free)

Answers to Questions About Eligibility and Claim Appeals
WV Public Employees Insurance Agency: 1-304-558-7850
or 1-888-680-7342 ext. 207 or 228 (toll-free) or on the web at www.wvpeia.com

SUBJECT TO CHANGE

The benefit information in this Policy is subject to change during the plan year (July 1, 2005 through June 30, 2006), if circumstances arise which require adjustment. Plan changes will be communicated to members through the mail at least 30 days before the changes are effective. These changes will be incorporated into the next edition of the Policy.

HOW TO USE THIS DOCUMENT

Being familiar with this Policy will help you get the most from your Plan – and in the quickest, easiest way possible! It can also help you avoid a bill for a service that was not covered or was required to be authorized in advance. For these reasons we suggest you:

1) Read this Policy as soon as you get it.
2) Keep it handy or where you can find it right away (it has many important phone numbers you may need later).
3) Refer to it whenever needed, especially if you are going to use health services that are not routine check-ups.

AccessWV'S SERVICE AGENTS

AccessWV has contracts with several agencies to provide you with quality services. These agencies are called third party administrators or TPA's. Their toll-free customer service telephone numbers are listed on page 2 of this booklet.

Who They Are and What They Do

1). **Administrative Services Partner**
Public Employees Insurance Agency (PEIA) is the administrative services partner of AccessWV. PEIA processes applications, coordinates communications with health care providers and payors, contracts with Acordia National and Express Scripts, Inc. (see below) and works with AccessWV to assure all operations are effective and efficient. Call Customer Service at 1-888-680-7342 ext. 207 or 228.

2) **Medical Claims and Utilization Manager**
Acordia National (Acordia) is the claims processor for all medical and hospital services for AccessWV. They also review services that must be prior authorized or pre-certified. Call Customer Service at 1-866-864-6142.

3) **Pharmacy Benefits Manager**
Express Scripts, Inc. (ESI) processes the claims for all prescribed drugs, maintains the preferred drug list, and can give you information you need about issues concerning your prescription drugs, such as drug interactions. In addition, they will send you an AccessWV insurance card. Call Customer Service at 1-877-256-4689.

IMPORTANT TERMS

The following terms are used throughout this Policy and are defined below as they pertain to AccessWV:

AccessWV: AccessWV is an insurance plan created by the State of West Virginia to meet the needs of specific state residents: those that are not able to obtain insurance though the private marketplace, those that have lost coverage due to changes in their employment status and those whose insurance has been cancelled by their employer. It is also referred to as a high risk pool plan.

Acordia National (Acordia): The third party administrator that processes and pays medical claims. It also reviews services that require pre-certification.

Allowed Amounts: For each AccessWV-covered service, the allowed amount is the lesser of the actual charge amount or the maximum fee for the service as set by PEIA.

Alternate Facility: A facility other than an acute care hospital.

Annual Deductible: The amount you must pay each plan year before the plan pays its portion of the cost. Only the Allowed Amounts for covered expenses will be applied to your deductible. The family deductible may be met by any combination of the enrolled family members; however, no one individual will be required to meet more than half of the family deductible.

Beacon Recovery Group (Beacon): The subrogation and recovery vendor for PEIA. Beacon pursues recovery of money paid for claims that were not the responsibility of AccessWV. For more information, read the "Recovery of Incorrect Payments" section beginning on page 55.

Benefit Year: The 12-month period beginning July 1 and ending June 30. This period is used to calculate any benefit maximums which may be reached.

Board of Directors: AccessWV is governed by a Board of seven individuals that are chosen by the Governor. The Board has representation from the insurance and hospital industries, those that are or could be members of the plan and others who represent the general community of West Virginia.

Claims Administrator: An organization that processes and pays medical claims through PEIA. Acordia and Express Scripts, Inc. are AccessWV's claims administrators.

Coinsurance: The percentage of eligible expenses that you are required to pay after the deductible has been met. This is the amount applied to your out-of-pocket maximum. You are responsible for paying the coinsurance and deductible amounts directly to the provider of services.

Common Specialty Medication: Specialty medications are high-cost injectable, infused, oral or inhaled drugs that generally require close supervision and monitoring of the patient's drug therapy. Specialty drugs have the following key characteristics:

- Need frequent dosage adjustments
- Cause more severe side effects than traditional drugs
- Need special storage, handling and/or administration
- Have a narrow therapeutic range
- Cost in excess of $1,300 per 30-day supply

Under AccessWV Common Specialty Medications are available only via mail order through Curascript, are subject to a $50 copay for up to a 34-day supply, and may not be purchased in larger quantities.

Copay or Copayment: This is the set dollar amount that you pay when you use the services—like the flat dollar amount you pay for an office visit. Copays do not count toward your annual out-of-pocket maximum or your annual deductible.

Curascript: The exclusive specialty pharmacy vendor for AccessWV. Through PEIA Curascript provides mail order delivery of the Common Specialty Medications detailed in the Prescription Drug Benefit section of this Policy.

Deductible: The amount of eligible expenses you are required to pay before the plan begins to pay benefits. The deductible does not apply to charges for office visits. Copays for office visits are not credited toward the deductible. See Annual Deductible above.

Dependent: An eligible person, as determined by AccessWV guidelines, whom the policyholder has properly enrolled for coverage under the Plan.

Durable Medical Equipment: Medical equipment that is prescribed by a physician which can withstand repeated use, is not disposable, is used for a medical purpose, and is generally not useful to a person who is not sick or injured.

Eligible Expense: A medically necessary, reasonable and customary item of expense for health care when the item of expense is covered at least in part by the Plan covering the person for whom the claim is made. Allowable expenses under this Plan are calculated according to PEIA fee schedules, rates and payment policies in effect at the time of service.

Emergency: An acute medical condition resulting from injury, sickness, pregnancy, or mental illness which arises suddenly and requires immediate care and treatment to prevent the death or severe disability of a member.

Exclusions: Services, treatments, supplies, conditions, or circumstances that are not covered under AccessWV.

Experimental, Investigational, or Unproven Procedures: Medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices for a particular case that are determined by the Plan to be: (1) not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service, the United States Pharmacopoeia Dispensing Information, or the American Medical Association Drug Evaluations as appropriate for the proposed use; or (2) subject to review and approval by any Institutional Review Board for the proposed use; or (3) the subject of an ongoing clinical trial that meets the definition of a Phase 1, 2, 3 Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or (4) not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

Explanation of Benefits (EOB): A form sent to the person in whose name a claim was filed after the claim has been processed by the Claims Administrator. The EOB explains the action taken on the claim. This explanation might include the amount paid, benefits available, reasons for denying payment, etc.

Express Scripts, Inc. (ESI): The pharmacy benefits manager that processes and pays claims for prescription drugs, provides drug information and carries out drug utilization management functions for the Plan.

Handicap: A medical or physical impairment which substantially limits one or more of a person's major life activities. The term "major life activities" includes functions such as care for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning or working. "Substantially limits" means interferes with or affects over a substantial period of time. Minor, temporary ailments or injuries shall not be considered physical or mental impairments which substantially limit a person's major life activities. "Physical or mental impairment" includes such diseases and conditions as orthopedic, visual, speech and hearing impairments; cerebral palsy; epilepsy; muscular dystrophy; autism; multiple sclerosis and diabetes. The term "handicap" does not include excessive use or abuse of alcohol, tobacco or drugs.

Health Care Tax Credit (HCTC) Eligibles: Those who are eligible to enroll in AccessWV because they are eligible for the HCTC program. HCTC will pay part of their monthy premiums.

Health Insurance Portability and Accountability Act (HIPAA) Eligibles: Those who are eligible to enroll in AccessWV because they have lost coverage once offered by their or their spouse's employer group plan.

In-Network, WV Provider: This network consists of all providers who are located in West Virginia and who provide health care services or supplies to any AccessWV member.

In-Network, Non-WV Provider: Network for services provided outside of the State of West Virginia. Contact Acordia National with questions about out-of-state providers.

Inpatient: Someone admitted to a hospital or skilled nursing facility as a bed patient for medical services.

Medical Case Management: A process by which PEIA through Acordia National assures appropriate available resources for the care of serious long-term illness or injury. Acordia National's case management program can assist in providing alternative care plans.

Medically Eligible: Those who are eligible to enroll in AccessWV because they have a pre-existing medical condition (1) that precludes their enrollment in any other individual health insurance plan within West Virginia or (2) allows enrollment for a similar insurance product, but at a higher premium.

Member: Any person who is eligible for and enrolled in an AccessWV Plan.

Notification: The required process of reporting an inpatient stay to AccessWV's utilization management vendor, Acordia National. This process is performed to screen for care planning, discharge planning, follow-up care and ancillary service requirements.

Out-of-Network Provider: A provider outside of the AccessWV network. Using these providers will require higher member participation in costs.

Outpatient: Someone who receives services in a hospital, alternative care facility, freestanding facility, or physician's office, but is not admitted as a bed patient.

Plan: AccessWV.

Plan Year: The 12-month period beginning July 1 and ending June 30. Benefits and limitations under this plan are administered on a plan year basis.

Policyholder: The person(s) who meets the eligibility requirements of AccessWV, enrolls in the plan, and in whose name the policy is issued.

Preauthorization: A voluntary program that allows you to obtain an advance review of a service to assure that it will be covered by the Plan. Preauthorization is handled by Acordia National.

Precertification: The required process of reporting any inpatient stay and certain outpatient procedures in advance to obtain approval for the admission or service. Acordia National handles precertification.

Pre-existing Condition: A physical or mental condition that had been diagnosed or treated, or for which the patient incurred expenses in the six months prior to becoming covered by the Plan.

Premium: The payment required to keep coverage in force.

Prior Authorization: The required process of obtaining authorization from the Rational Drug Therapy Program for coverage for some prescription medications under the AccessWV Plan.

Provider: A hospital, physician, or other health care provider. A health care professional must be licensed and qualified under the laws of the jurisdiction in which the care is received and must be providing treatment within the scope of his or her professional license. If the service is provided by a medical facility such as a hospital or treatment center, the facility must be a participating Medicare facility or approved by the Joint Commission on Accreditation of Health Organizations (JCAHO).

Provider Discount: A previously determined percentage that is deducted from a provider's charge or payment amount and is not billable to the member when AccessWV is the primary payer and the service is provided within West Virginia.

Pubic Employees Insurance Agency (PEIA): The administrative services partner of AccessWV which determines eligibility, processes enrollments, provides customer service, and contracts with the TPAs to provide other services under this plan.

Rational Drug Therapy Program (RDT): The Rational Drug Therapy Program of the WVU School of Pharmacy provides clinical review of requests for drugs that require prior authorization under the AccessWV Plan.

Reasonable and Customary: The prevailing range of fees charged by providers of similar training and experience, located in the same area, taking into consideration any unusual circumstances of the patient's condition that might require additional time, skill or experience to treat successfully.

Secondary Payer: The plan or coverage whose benefits are determined after the primary plan has paid. Order of payment is determined by rules described under "Coordination of Benefits" on page 55.

Subrogation: The right of AccessWV to succeed to a member's right of recovery against a third party for benefits paid by AccessWV, or on behalf of, a member for services incurred for which a third party is, or may be, legally liable. Basically, this is a repayment to AccessWV of medical costs paid for by the Plan due to an illness or injury wrongfully caused by someone else (as in an auto accident, for example). This usually occurs after repayment by another insurer or court settlement.

Third Party Administrator (TPA): A company with which PEIA has contracted to provide services such as customer service, utilization management and claims processing to AccessWV Plan members. The TPAs for AccessWV are Acordia National and ESI.

Utilization Management: A process by which AccessWV controls health care costs. Components of utilization management include pre-admission and concurrent review of all inpatient stays, known as precertification; prior review of certain outpatient surgeries and services; and medical case management. Utilization management is handled by Acordia National.

Eligibility & Membership

WHEN COVERAGE STARTS

Coverage begins on the first day of the month following acceptance of your completed application; this is known as your effective date of coverage. Services received on or after the effective date of coverage are eligible for consideration for payment by AccessWV. Services received prior to your effective date of coverage are ineligible.

You should have received a letter notifying you of your member number and effective date of coverage a few days prior to the first day you became enrolled in AccessWV. You should receive your official medical and prescription drug ID card along with a copy of the Preferred Drug List by the middle of the first month of your enrollment. This Policy came as a part of a Welcome Kit that also included a list of commonly asked questions and answers about AccessWV and a list of important phone numbers.

Renew Enrollment Each Year

Policyholders will receive an annual Eligibility Survey in May which will ask you to provide proof of your continued residency in West Virginia. Policyholders can renew enrollment by completing and returning the mandatory survey in the allotted timeframe. If the completed survey is not returned by the specified return-by date, enrollment shall cease. Also in May of each year, you will be provided information about any changes in the plan for the following year. You may also change Plans during May of each year. These changes will be effective on July 1st.

Changing Plans During the Year

Policyholders and enrolled dependents may transfer among Plans A, B and C if:

- the policyholder requests a change during the program's open enrollment period which is held in May. Policyholders will receive information regarding any changes to the plans at that time. All open enrollment transfers will be effective July 1. All enrolled dependents will also be transferred to the new plan on that date. Members who transfer among plans during open enrollment are not subject to pre-existing condition limitations if they have already met the requirement in AccessWV.

- the policyholder has had a substantial change in life situation which includes a marriage or dissolution of marriage, birth or adoption of a child or court-ordered guardianship of a child or dependent adult child which necessitates moving from single coverage to family or vice versa. All requests for transfers submitted in writing on a Change Form by the 15th of the month will be made effective on the first day of the subsequent month. Changes received after the 15th will be effective the first of the second subsequent month. For example, if your Change Form is received on August 10, the change in your coverage will be effective on September 1, but if your Change Form is received on August 21, the change in your coverage will not be effective until October 1.

Call PEIA at 1-888-680-7342 ext. 207 or 208 to request a copy of the Change Form.

DEPENDENTS

Coverage for a policyholder's legal spouse and/or children or others for whom the policyholder has court-appointed guardianship is available through AccessWV. Examples include biological or adopted children or step children. Dependents are eligible for coverage provided they are residents of West Virginia and they meet one of the following requirements:

- The dependent is unmarried and under the age of 19;
- The dependent is unmarried, enrolled full-time at an accredited educational institution and under the age of 23;
- The adult dependent child is incapable of self-sustaining employment by reason of mental or physical disability and is chiefly dependent upon the policyholder for support or maintenance. AccessWV may require proof of the incapacity in order for the policyholder to elect to continue the policy in force with respect to the mentally or physically disabled dependent.

Premium rates for those applying for family coverage (i.e. applicant and applicant's spouse and/or dependents) are listed on the premium sheet you received as a part of your application packet. Single and family premium rates are determined by the age and gender of the policyholder and the county of residence.

Changing Dependents

If you wish to add new dependents, such as a new spouse, your biological newborn or adopted child, you must call PEIA to request a Change Form to change enrollment to add them to your coverage. You do not need a Social Security Number to enroll your newborn, but when you obtain a Social Security Number for the child, please provide it to PEIA.

If you wish to add or change coverage for any other dependents, you must submit a Change Form to change enrollment. Call PEIA at 1-888-680-7342 ext. 207 or 208 to request a copy of the Change Form.

PRE-EXISTING MEDICAL CONDITIONS

"Pre-Existing Medical Condition" refers to any condition for which you have been treated or with which you have been diagnosed with during the six months immediately preceding enrollment in AccessWV. Any policyholders and/or dependent(s) enrolling in AccessWV will be subject to pre-existing condition limitations.

If you have a Pre-Existing Medical Condition, AccessWV will not pay for any services (either medical or pharmacy) related to the pre-existing condition for the first six months of your enrollment. It will pay for services related to a newly experienced injury or illness and for needed preventive care.

If a medical or pharmacy claim is submitted to AccessWV for health services that appear to be related to a pre-existing illness or condition, information will be requested from your provider regarding the diagnosis to determine if the service relates to a condition that you had six months or less before your enrollment date.

Note: Persons who qualify for AccessWV under the HIPAA and some HCTC eligible persons will not have a pre-existing condition exclusionary period, meaning that all eligible claims will be paid as of the effective date.

WHEN COVERAGE ENDS

Certain events will cause AccessWV membership for you and/or your covered dependents to terminate. Generally, coverage will end if you or a dependent become ineligible. AccessWV coverage for a policyholder and covered dependents may be terminated by the policyholder as a voluntary termination, or by the plan as an involuntary termination if the plan determines certain events have taken place.

Once enrolled, a policyholder will continue to be a member of AccessWV, as long as the policyholder continues to pay the required premiums and answers the annual Eligibility Survey unless one of the following things occurs:

- Policyholder becomes eligible for other individual coverage because his/her condition has improved; **or**
- Policyholder becomes eligible for group coverage through employer or union or member's spouse's employer or union; **or**
- Policyholder permanently moves out of West Virginia; **or**
- Policyholder becomes eligible for Medicare, Medicaid or WVCHIP (unless the member has reached the benefit limit and is no longer eligible to be a WVCHIP member); **or**
- AccessWV expends the $1,000,000 lifetime maximum of benefits on the policyholder (at which time the policyholder and all dependents are cancelled by the plan); **or**
- Policyholder requests disenrollment in writing; **or**
- Policyholder has committed an act of fraud to circumvent the statutes or regulations of AccessWV; **or**
- Policyholder becomes an inmate or resident of a public institution, which means a Federal or State prison or correctional institution or a Veteran's Home.

Voluntary Termination

For voluntary terminations, policyholders must provide AccessWV written notice of their intent to disenroll by the 15th of the month for enrollment to cease at the end of that month. Alternatively, coverage will cease at the end of the month in which the policyholder voluntarily ceases to pay premiums.

Involuntary Termination

AccessWV may cancel coverage for the policyholder and dependents if the:

- Policyholder fails to pay premium when due; **or**
- Policyholder moves out of West Virginia permanently; **or**
- Policyholder become eligible for Medicare, Medicaid, WVCHIP (unless the member has reached the benefit limit and is no longer eligible to be a WVCHIP member); **or**
- Policyholder becomes eligible for similar or more comprehensive policy; **or**
- AccessWV expends the $1,000,000 lifetime maximum of benefits on the policyholder (at which time the policyholder and all dependents are cancelled by the plan); **or**
- Policyholder dies; **or**
- Annual Eligibility Survey is not returned by the specified return-by date; **or**
- Policyholder or dependent has committed an act of fraud to circumvent the statutes or regulations of AccessWV; **or**
- Policyholder becomes an inmate or resident of a public institution, which means a Federal or State Prision or correctional institution or a Veteran's Home.
- State Law requires cancellation of the policy.

Termination of Dependents

Coverage for dependents terminates at the end of the calender month in which one of the following occurs:

- policyholder is no longer eligible for coverage; **or**
- dependent spouse is divorced from policyholder; **or**
- dependent child reaches 19th birthday; **or**
- dependent child who has extended coverage beyond the age of 19 as a full-time student reaches his/her 23rd birthday or ceases full-time student status (Note: see section below on Special Eligibility Situations for full-time students); **or**
- dependent child marries; **or**
- dependent becomes eligible for Medicare, Medicaid, or WVCHIP; **or**
- disabled dependent no longer meets disability guidelines; **or**
- AccessWV expends the $1,000,000 lifetime benefit maximum on the dependent member
- dependent is no longer a resident of West Virginia; **or**
- dependent becomes an inmate or resident of a public institution, which means a Federal or state prison or correctional facility or a Veterans' home; **or**
- policyholder voluntarily removes dependent from coverage.

Upon determination that a member is no longer eligible for AccessWV coverage, the policyholder will receive notification of the termination in the mail at least 30 days before the termination date except in the case of nonpayment. This notification will include the reason for the termination, date of termination and notice of appeal rights. In no case will coverage extend beyond the period for which premiums have been paid. If coverage for the policyholder is terminated, coverage for the dependents is also terminated.

Members who have terminated coverage for any reason are not eligible to re-apply for AccessWV coverage for 12 months after the cancellation effective date.

YOUR RESPONSIBILITY TO MAKE CHANGES

It is your responsibility to keep your AccessWV enrollment records up to date. You must notify AccessWV immediately of any changes in your family situation and take the necessary steps to keep your AccessWV coverage up to date. Examples of such changes include a change of address, a change in your marital status, or a dependent child no longer qualifying for coverage.
Premiums will be based on age, gender and geographic location of the policyholder. The policyholder's county of residence will determine which of the four regional premiums they will be charged.

SPECIAL ELIGIBILITY SITUATIONS

Full-Time Students Age 19 and Over—Student Verification

Coverage for a dependent child ceases at the end of the month in which the child reaches age 19; however, coverage may be extended (on a year-to-year basis) to age 23 if the child is unmarried, enrolled as a full-time student, and dependent on you for support and maintenance. "Enrolled as a full-time student" means the child attends courses full-time (as determined by the institution) in a graduate or undergraduate college or university (other than a U.S. Military academy when the academy considers the student to be on active duty) or attends a trade or professional school as the child's full-time occupation. Student verification is a two-step process:

1. Verification of full-time student status will be requested by AccessWV when your child turns age 19.
2. Once a year thereafter, you must verify your child's full-time student status by providing a letter from the school's registrar. AccessWV coverage for a dependent who is a full-time student during the Spring semester will continue through August 31 of that same year, provided the dependent is unmarried and not over age 23.

If your child loses eligibility because he or she is no longer a full-time student, you should notify AccessWV promptly. If your child (between the ages of 19 and 23) voluntarily withdraws from school, has a lapse in coverage, and later re-enrolls as a full-time student, he or she may be reinstated for AccessWV coverage. Call PEIA to request a Change Form to add this child to your list of dependents to reinstate this coverage. This child may be subject to pre-existing condition limitations.

Disabled Dependents

Your dependent child may be covered after reaching age 19 if he or she is incapable of self-support because of mental or physical disability. To be eligible:

- the disabling condition must have begun before age 19, or before age 23 if a full-time student; and
- the child must be incapable of self-sustaining employment and chiefly dependent on you for support and maintenance.

To continue this coverage, submit a letter detailing the child's information and disability to AccessWV. AccessWV may contact you if more information is needed. You will be asked to provide documentation when the child reaches age 19 and periodically thereafter.

MEMBER IDENTIFICATION CARDS

You will receive a member identification card within 15 days of your effective date in AccessWV. Your AccessWV ID card verifies that you have medical and prescription drug coverage under AccessWV. On the back we've listed important phone numbers you may need. One card will be issued for individual coverage, and two cards will be issued for family coverage. The policyholder's name and identification number will be printed on all cards. If you want additional cards or if you need to replace a lost card, please contact Express Scripts at 1-877-256-4680.

PREMIUMS

By law, AccessWV premiums are based on the price charged by other insurers offering health insurance coverage to individuals coverage in West Virginia. Premiums are generally updated on July 1st of each year. You will receive notice by mail of any changes at least 30 days prior to the effective date.

Premiums are based on age, gender and geographic location of the policyholder. The policyholder's county of residence will determine which of the four regional premiums you will be charged.

The policyholder is solely responsible for notifying the plan of changes in residence while a member of the plan. If there is a move which changes the policyholders' premium regions, the premium will be adjusted to the new regional rate. If the plan administrator becomes aware of the change by the 15th of the month, the premium will change on the first day of the subsequent month. If the plan administrator becomes aware after the 15th of the month, the premium will change as of the first day of the second subsequent month.

Since the premiums are structured in five-year age bands, when the policyholder ages into the next age band, the plan administrator will change the premium to reflect the new rate as of the first of the month after the policyholder's birth date.

Premium Billing

Members will be given the option of payment by check, money order or automatic withdrawal from their bank account. For members not on automatic withdrawal, billing statements will be mailed by the 10th of each month for next month's premium. The premium is due by the 1st of the month for coverage in that month. For example, you will receive a statement just after October 10th, for the premium that is due on November 1st. The premium due on November 1st, pays for coverage for the month of November.

Failure To Pay Premium

Your coverage as a policyholder, and coverage of your dependents, will terminate if you fail to pay your premium contributions when due. Premiums are due by the 1st day of the month for coverage in that month. Example: May premium is due May 1st. If payment is not received within 15 days following the due date, coverage will be cancelled as of the last day of the month for which you paid a premium. In this example, coverage would be cancelled as of April 30th, and all claims incurred during May will be your personal responsibility.

Health Care Benefits

AccessWV Plans

AccessWV pays for a wide range of health care services for members and their dependents. These benefits include hospital services, medical services, surgery, durable medical equipment and supplies, and prescription drugs.

Under AccessWV, certain costs are your responsibility. In addition, to receive maximum benefits for some services, precertification is required or your benefits will be reduced. Please read this health care benefits section carefully so that you will have a clear understanding of your coverage under AccessWV.
If you have any questions about coverage or payment for health care services, please call:

Where to Call with Questions		
Medical claims, benefits, precertification, case management, preauthorizations and prior approvals for out-of-state care	Acordia	1-866-864-6142
Prescription drug claims and benefits	Express Scripts	1-877-256-4680
Common Specialty Medication claims and benefits	Curascript	1-866-413-4135

WHAT YOU PAY

Medical Deductible

During any plan year, if you or your eligible dependents incur expenses for covered medical services (other than office visits), you must meet a deductible before the plan begins to pay. Your deductibles are shown on your Summary of Benefits. Medical deductibles are based on whether you get your services within the AccessWV network or outside of the network.

The family deductible is twice the single deductible. The family deductible is divided among the family members. No one member of the family will pay more than the single deductible. Once that person has met the single deductible, the plan will begin paying on that person. When another member of the family meets the single deductible, then the plan will begin paying on the entire family. Alternatively, all members of the family may contribute to the family deductible with no one person meeting the single deductible; once the family deductible is met, the plan pays on all members of the family.

For inpatient admissions that span two plan years, the facility charges are paid based on the first plan year, but physician charges are paid based on the date of service, which could be in the first plan year, new plan year or both plan years. For example, if you go into the hospital on June 28 and are released on July 6, the hospital bill is paid based on the date of admission, so it would fall under the previous plan year's deductible. Physician charges are paid based on the date of service, so if you have surgery on July 2, the surgeon's bill will be processed based on the new plan year, and the deductible for the new plan year will apply to the surgeon's bill.

The out-of-network deductible satisfies the in-network deductible, but the in-network deductible does not meet the out-of-network deductible. This means that even if you have met the in-network deductible, you will be responsible for the full out-of-network deductible. Out-of-network deductibles are twice the amount of in-network deductibles.

The annual medical deductible will be pro-rated if you first enroll in AccessWV after the first quarter of the plan year. For example, if you first enroll in January for single coverage, your medical deductible will be half of what the full year deductible would be for July through June. Pro-rating will not apply in the case of a change between coverage types (single and family).

Prescription drug benefits are subject to a separate deductible. Please see the "Prescription Drug Benefit" section starting on page 38 for information.

COINSURANCE FOR IN-NETWORK, IN-NETWORK NON WV AND OUT-OF-NETWORK BENEFITS

AccessWV is designed to provide as much care as possible within the State of West Virginia. For services with coinsurance requirements, your coinsurance percentage is lowest for care received from in-network providers in West Virginia.

Source of Care	Your Coinsurance
In-Network services in West Virginia	20%
In-Network services outside West Virginia	30%
Out-of-Network services	40%

COST SHARING

The following section provides you with a description of services and your cost-share.

Covered in Full

The following services are covered in full in-network using West Virginia providers:

Type of Service	Your In-Network Cost
Routine prenatal care (physician services)[1]	$0; Covered in full
Well child exams and immunizations[2]	$0; Covered in full
High risk birth score program	$0; Covered in full
Annual screening mammogram[3]	$0; Covered in full
Annual Pap Smear[3]	$0; Covered in full
Colorectal cancer screening[3]	$0; Covered in full
Prostate cancer screening[3]	$0; Covered in full

[1] Deductible applies only if not met with charges for hospital or other services.

[2] Also covered in full in-network, outside WV and out-of-network .

[3] Testing covered in full. Office visit copay applies.

Copayment Only

A copayment is a flat dollar amount you pay when you receive service(s) from a provider. When a service is subject to a copayment only, you do not have to meet the deductible before AccessWV begins to pay for that service. The copayment does not count toward your deductible or your out-of-pocket maximum.

Type of Service	Your In-Network, WV Cost
Physician Office Visits - preventive care	$10 copay per visit with no deductible
Physician Office Visits - treat illness or injury	$15 copay per visit with no deductible
Adult Routine Physical Exams	$10 copay per visit with no deductible
Second Surgical Opinions*	$15 copay per visit with no deductible

*No copayment if required by Acordia National.

Copay, Coinsurance and Deductible

The In-Network, WV services listed in the chart below are subject to a copay, annual deductible, and coinsurance:

In-Network Services in West Virginia	
Emergency Services (including supplies) at emergency room	$25 copay + deductible + 20% coinsurance
Non-Emergency Services at emergency room	$50 copay + deductible + 20% coinsurance
Ambulatory surgery/ Outpatient surgery	$50 copay + deductible + 20% coinsurance

The In-Network, Non-WV services listed in the chart below are subject to a copay, annual deductible, and coinsurance:

In-Network Services Outside West Virginia	
Emergency Services (including supplies) at emergency room	$25 copay + deductible + 20% coinsurance
Non-Emergency Services at emergency room	$50 copay + deductible + 30% coinsurance
Ambulatory surgery/ Outpatient surgery	$75 copay + deductible + 30% coinsurance

The Out-of-Network services listed in the chart below are subject to a copay, annual deductible, and coinsurance:

Non-Network Services	
Inpatient hospital (semi-private room, ancillary services, etc.)	$500 copay + deductible + 40% coinsurance
Maternity care (delivery)	$500 copay + deductible + 40% coinsurance
Rehabilitation	$500 copay + deductible + 40% coinsurance
Inpatient mental health and chemical dependency (including partial hospitalization)	$500 copay + deductible + 40% coinsurance
Inpatient detoxification	$500 copay + deductible + 40% coinsurance
Emergency services including supplies	$25 copay + deductible + 40% coinsurance
Non-Emergency Services at emergency room	$50 copay + deductible + 40% coinsurance
Skilled nursing facility	$500 copay + deductible + 40% coinsurance
Ambulatory/Outpatient surgery	$100 copay + deductible + 40% coinsurance

Coinsurance and Deductible

Generally, services not listed in the five preceding charts are covered at 80% after the deductible is met for in-network, WV care; at 70% after the deductible is met for in-network, non-WV care; and at 60% after the out-of-network deductible is met for non-network care. You pay your deductible, coinsurance, and any charges for services not covered by the plan directly to your health care provider.

BENEFIT LIMITS

For certain types of services, the plan will pay a limited amount per plan year as shown below. Members experiencing a severe medical episode and members with very complicated medical conditions are assigned a nurse case manager. For these catastrophic cases, the case manager may, based on medical documentation, recommend additional treatment for services marked with an asterisk (*). For details of these benefits, see "What Is Covered" beginning on page 25.

Annual Benefit Limits

Type of Service	Benefit Limit (per member per plan year)
*Outpatient Mental Health/Chemical Dependency	20 visits
Christian Science Treatment	$1,000
*Outpatient Therapy Services (includes all benefits listed in this category under What is Covered)	20 visits (total amount allowed for all therapies combined)
Inpatient Rehabilitation	150 days
Skilled Nursing Facility	100 day
Impatient mental health / chemical dependency	30 days
Cardiac or pulmonary rehabilitation sessions	36 sessions

*May be extended if approved by Acordia National.

Medical Out-of-Pocket Maximum

The medical out-of-pocket maximum is the most you pay in coinsurance in a plan year. Amounts you pay toward your annual deductibles for copayments, for precertification penalties, for prescription drugs, for amounts billed in excess of what AccessWV pays to non-network providers, and for services that are not covered under the plan do not apply toward your annual medical out-of-pocket maximum. It includes only your medical charges; prescriptions are handled separately. See the "Prescription Drug Benefit" section starting on page 38 for details. Once you have met your out-of-pocket maximum, the plan will pay 100% of your covered charges (less applicable copayments and deductibles) for the remainder of the plan year. Your out-of-pocket maximum amount depends on whether you are enrolled in an individual or family plan and whether you receive services in-network or out-of-network. The out-of-pocket maximums are shown in the "Summary of Benefits".

The family out-of-pocket maximum is twice the single out-of-pocket maximum. Once a family member has reached the single, out-of-pocket maximum, AccessWV will begin paying 100 percent of covered charges (less applicable copays and deductibles) for that family member. When another family member meets the single out-of-pocket maximum, AccessWV will being paying 100 percent of covered charges (less applicable copays and deductibles) for the entire family. Alternatively, all members of the family may contribute to the family out-of-pocket maximum with no one person meeting the single out-of-pocket maximum. Once the family maximum is met, AccessWV pays 100 percent of covered charges (less applicable copays and deductibles) for the entire family.

Amounts paid toward the out-of-network out-of-pocket maximum will also count toward the in-network out-of-pocket maximum, but in-network amounts do not count toward the out-of-network out-of-pocket maximum. The full out-of-network out-of-pocket maximum will have to be met before AccessWV pays 100 percent.

Annual Benefit Maximum

AccessWV has an annual benefit limit of $200,000 per member for each plan year for medical benefits. Benefits paid under the Prescription Drug Plan have a $25,000 per member limit. This limit includes only the actual dollars paid by the plan on behalf of the member.

Once the plan expends either annual benefit limit, the member must continue to pay premiums to maintain membership with AccessWV. If the member chooses to cancel coverage, he or she must wait 12 months after termination of coverage to re-apply to AccessWV and will be subject to a waiting period for pre-existing conditions.

Lifetime Maximum

AccessWV will pay a maximum of $1,000,000 in benefits per person during each member's lifetime. Benefits paid under the Prescription Drug Plan are included in this maximum. Once this maximum is reached,the member's coverage will be terminated by the Plan. If the member is the policyholder, coverage will be terminated for the policyholder and dependents.

Pre-Existing Condition Six-Month Waiting Period

If you have a pre-existing condition that requires a six-month waiting period before claims will be paid, medical claims may be denied. If coverage is denied due to waiting period, you will be required to pay the full amount of the claim. This applies only to care received related to your pre-existing condition. Care for new illness or injuries will be paid as outlined.

AccessWV PLAN FEE SCHEDULES AND RATES

AccessWV pays health care providers according to a maximum fee schedule and rates established by PEIA. If a provider's charge is higher than the PEIA maximum fee for a particular service, then the plan will allow only the maximum fee. The "allowed amount" for a particular service will be the lower of the provider's charge or the PEIA maximum fee.

Physicians and other health care professionals are paid according to a Resource Based Relative Value Scale (RBRVS) fee schedule. This type of payment system sets fees for professional medical services based on the relative amount of work, practice expense and malpractice insurance expense involved. These rates are adjusted annually. West Virginia physicians who treat AccessWV members must accept PEIA's allowed amount as payment in full; they may not bill additional amounts to AccessWV members other than allowable deductibles, copays and coinsurance.

West Virginia hospitals that provide inpatient services are paid on a "prospective" basis. AccessWV's reimbursement to hospitals is based on PEIA's Diagnosis-Related Groups (DRGs), which is the system used by Medicare. It is a Prospective Payment System (PPS) that classifies medical cases and surgical procedures on the basis of diagnoses. Under this system, West Virginia hospitals know in advance what PEIA will pay per day or per admission. West Virginia hospitals have been provided specific information about their reimbursement rates from PEIA. These rates are adjusted annually. West Virginia hospitals that treat AccessWV members must accept PEIA's allowed amount as payment in full; they may not bill additional amounts to AccessWV members other than allowable deductibles, copays and coinsurance.

PROVIDER NETWORKS

AccessWV is designed to provide as much care as possible within the State of West Virginia. The AccessWV Network is made up of West Virginia health care providers who provide health care services or supplies to AccessWV members. For services provided outside of the State, several networks are available.

AccessWV Plan Members

AccessWV Plan members may receive care from any of the following providers; however, your coinsurance level will be higher if you use non-network or out-of-state providers:

1. any West Virginia health care provider who provides health care services or supplies to an AccessWV member (20% coinsurance)
2. any network provider outside West Virginia (30% coinsurance)
3. any non-network provider outside West Virginia (40% coinsurance)

In addition to coinsurance, you will be responsible for any copays or deductibles associated with the service. All services, except emergency care, provided outside of West Virginia will require higher coinsurance from the member.

You will not be responsible for any balance billing by providers within West Virginia. You will be responsible for any balance billing by providers outside of West Virginia, and those amounts are considered non-covered services. They do not count toward the deductible or out-of-pocket maximum.

AccessWV provides care through several networks of providers. In West Virginia, any health care provider who provides health care services or supplies to an AccessWV member is automatically considered a member of our network. Outside West Virginia, there are several networks available. Generally, the available networks are:

- **Medical Mutual of Ohio's SuperMed Plus Network (in Ohio only)**. To locate providers in the state of Ohio who participate in Medical Mutual of Ohio's (MMO) SuperMed Plus network, call 1-866-864-6142, or check the internet at www.supermednetwork.com.
- **The Alliance Network** (in Maryland, Washington, DC, and North Carolina only). (For physicians associated with Duke University, PEIA uses the Beech Street Network). To locate providers in Maryland, North Carolina and the District of Columbia (DC) who participate in the Alliance Network, call 1-866-864-6142, or check the internet at www.mamsi.com/directory.
- **The Beech Street Network** in all other states. To locate providers who participate in the Beech Street network, call 1-866-864-6142, or check the internet www.beechstreet.com. For Plan Year 2006, Kings Daughters Medical Center and Our Lady of Bellefont Hospital in Ashland, Kentucky, and hospitals in the UPMC Health System are not participating hospitals in the AccessWV Plan.

In addition, Acordia National contracts with some out-of-state providers to serve AccessWV members only. To locate a network provider in any of the available networks, call Acordia National at 1-866-864-6142. Care provided by out-of state or non-network providers will be paid at a lower level. Not all hospitals in these networks may participate with AccessWV. AccessWV reserves the right to remove providers from the networks, so not all providers in all networks may be available to you. Providers who are under sanction by Medicare, Medicaid or both will be expelled from the network for the duration of their sanction. In cases of expulsion, both the provider and the patient will be notified by mail of the action before claims are denied.

In-Network Providers Outside of West Virginia

For services provided outside the State of West Virginia, Acordia National utilizes several network relationships. These networks review their providers for quality standards like licensing, background and treatment patterns. As part of their agreement with the network, the amount paid for services is a discounted amount. After you receive medical attention, your claim will be routed to Acordia National. All in-network, non-WV providers are paid directly, relieving you of any hassle and worry. You will need to pay for out-of-pocket expenses (deductibles, copayments, coinsurance amounts and non-covered services). Acordia National will send you an Explanation of Benefits (EOB).

If you have questions about a specific network provider, please contact Acordia National at 1-866-864-6142.

PRECERTIFICATION/NOTIFICATION/PREAUTHORIZATION REQUIREMENTS

Precertification of Inpatient Admissions (Mandatory)

AccessWV requires that certain services and/or types of services be reviewed to determine whether they are medically necessary and to evaluate the necessity for case management. Some services require "precertification," and other services require "notification." Precertification is performed to determine if the admission/service is medically necessary and appropriate based on the patient's medical documentation. Notification to Acordia National is required to evaluate the admission/service in order to determine if the patient's medical condition will require case management, such as discharge planning for home health care services.

Precertification is required for the following:

Inpatient Admissions

1. hysterectomy,
2. laminectomy,
3. insertion of implantable devices (vascular access, pacemakers, implantable pumps, spinal cord stimulators, neuromuscular stimulators, bone growth stimulators),
4. uvulopalatopharyngoplasty,
5. Leforte osteotomy,
6. elective and cosmetic surgeries (breast reduction, blepharoplasty, abdominoplasty, breast reconstruction, surgery for varicose veins),
7. bariatric surgery (gastric bypass, etc.),
8. transplants,
9. mental health, and
10. all admissions to out-of-state hospitals/facilities.

Outpatient Services

1. allergy testing for more than 70 skin pricks and/or intradermal sticks,
2. home health care services for more than 3 days/visits,
3. partial/day mental health programs,
4. MRI (magnetic resonance imaging),
5. multidisciplinary pain management programs,
6. durable medical equipment purchases and/or rentals of $1,000 or more, and
7. surgeries:
   a. hysterectomy,
   b. laminectomy,
   c. implantable devices (vascular access, pacemakers, implantable pumps, spinal cord stimulators, neuromuscular stimulators, bone growth stimulators),
   d. uvulopalatopharyngoplasty,
   e. Leforte osteotomy,
   f. elective and cosmetic surgeries (breast reduction, blepharoplasty, abdominoplasty, breast reconstruction, treatment for varicose veins),
   g. bariatric surgery (gastric bypass, etc.), and
   h. transplants.

Notification

Notification to Acordia National is required for the following inpatient admissions to WV facilities:

1. medical (non-surgical),
2. surgical admissions (except those specifically listed as requiring precertification),
3. emergency (including chest pain and congestive heart failure, and other cardiac events), and
4. maternity and newborn.

Failure to precertify or notify Acordia of an admission within the timeframes specified in the chart below will result in a reduction of benefits under AccessWV of 30%. This 30% penalty will be the responsibility of network providers. For all non-network providers, this 30% penalty will be the responsibility of the insured in addition to any applicable copayment, coinsurance, deductible, and amounts that exceed AccessWV's maximum allowance.

If the insured or provider feels that Acordia inappropriately denied an admission or the extension of an admission, or that extenuating circumstances existed that prevented notification to Acordia National within the timeframes set forth, the insured or provider may file an appeal.

Timely Precertification Requirements	
Type of Admission	**Advance Notice Required**
Scheduled:	
Planned admission	5 business days in advance
Inpatient elective surgery or procedure	5 business days in advance
Maternity (notify Acordia National during your first trimester)	
Term pregnancy	Within 48 hours of admission
Caesarean section (planned)	5 business days in advance
Caesarean section (emergency)	Within 48 hours of admission
Urgent/Emergency	Within 48 hours of admission
Extended stay	Additional days may be recommended based on medical necessity

Exception: *It is the member's responsibility to precertify inpatient stays and outpatient procedures when these services are received out-of-network. If you do not precertify these out-of-network services, you must pay the 30% precertification penalty in addition to the out-of-network copayment, coinsurance, deductible and amounts that exceed PEIA's maximum allowance.*

Preauthorization

Preauthorization is a program which allows you to contact Acordia National in advance of a procedure to verify that the service is covered and will be paid so that you can make an informed decision about the procedure. Obtaining preauthorization from Acordia National assures that your claim will be paid when it is submitted. To obtain preauthorization, ask your provider to send your request to:

Acordia National
P. O. Box 2451
Charleston, WV 25329-2451

Your provider should include your name, address, telephone number, your Social Security Number, and all information about the recommended procedure. Acordia National may contact your physician for more information. Remember, if your request for preauthorization is denied, you will be responsible for paying for the procedure if you choose to have it.

Due to specific benefit criteria, preauthorization is recommended for the following procedures:

- Chelation Therapy
- Massage Therapy
- Vision Therapy
- Accident-Related Dental Services
- Orthotics

MEDICAL CASE MANAGEMENT

If you are experiencing a serious or long-term illness or injury, Acordia National's medical case management program can help you learn about available resources, provide early support for your family, and find ways to contain medical costs, including your out-of-pocket expenses. Through case management Acordia National can:

- arrange home care to prevent hospitalization;
- arrange services in the home to facilitate early hospital discharge;
- obtain discounts for special medical equipment;
- locate appropriate services to meet the patient's health care needs; and
- for catastrophic cases, when medically proven as a part of a comprehensive plan of care, allow additional visits for outpatient mental health or outpatient therapy services.

Acordia National must be notified for medical case management for the following services:

- home health care of more than three (3) visits, including but not limited to:
  a. skilled nursing visits;
  b. I.V. therapy in the home;
  c. physical therapy, occupational therapy or speech therapy done in the home;
  d. hospice care; and
  e. medication provided or administered by a home health agency.
- skilled nursing facility services; and
- rehabilitation services.

WHAT IS COVERED

Medically Necessary Services

Covered services must be medically necessary or be one of the specifically listed preventive care benefits. Medically necessary health care services and supplies are those provided by a hospital, physician or other licensed health care provider to treat an injury, illness or medical condition. A service is considered medically necessary if it is:

- consistent with the diagnosis and treatment of the illness or injury;
- in keeping with generally accepted medical practice standards;
- not solely for the convenience of the patient, family or health care provider;
- not for custodial, comfort or maintenance purposes;
- rendered in the most cost-efficient setting and level appropriate for the condition; and
- not otherwise excluded from coverage under the AccessWV Plan. The fact that a physician has recommended a service as medically necessary does not make the charge a covered expense.

AccessWV reserves the right to make the final determination of medical necessity based on diagnosis and supporting medical data.

Types of Medical Services Covered

AccessWV covers a wide range of health care services. Some major categories are listed below. The description of each service includes the level of coinsurance and any applicable copayments you must pay when the service is received from a provider within the State of West Virginia.

Services you receive from providers outside West Virginia and from non-network providers are subject to higher levels of coinsurance. See page 21 for details. If you have questions about coverage, call Acordia National at 1-866-864-6142.

- **Acupuncture.** Services of a licensed acupuncturist for treatment of medical conditions are included in the Outpatient Therapy Benefit (see below) and are covered at 80% after the in-network deductible. Contact Acordia National for specific benefit limitations. Combined coverage for these therapies is limited to a maximum of 20 visits per person per plan year. Office visits are covered with a $15 copay and treatments are covered at 80% after the deductible is met.
- ◆ **Allergy Services.** Including testing and related treatment; in-network care covered at 80% after in-network deductible is met. Allergy testing (for more than 70 tests) requires precertification.
- **Ambulance Services**. Emergency ground or air ambulance transportation, when medically necessary, to the nearest facility able to provide needed treatment; in-network care covered at 80% after in-network deductible. Non-emergency transportation is not covered.
- ◆ **Ambulatory Surgery.** This benefit is subject to a $50 copay and 20% coinsurance. The copay and coinsurance amounts apply after the in-network deductible has been met. See "Outpatient Surgery" on page 30. Certain procedures require precertification.
- **Cardiac or Pulmonary Rehabilitation**. Benefits are limited to 3 sessions per week for 12 weeks or 36 sessions per year for the following conditions: heart attack in the 12 months preceding treatment, heart failure, coronary by-pass surgery or stabilized angina pectoris. Covered at 80% after in-network deductible is met.
- **Chelation Therapy.** Benefits for these services are limited. Contact Acordia National for preauthorization. If covered, in-network therapy is paid at 80% after the in-network deductible has been met.
- **Childhood Immunizations**. Immunizations for children through age 16 are covered at 100% of allowed charges, including the office visit. This benefit is not subject to deductible, coinsurance, or copayment.
- **Chiropractic Services.** Services of a chiropractor for treatment of neuromuscular-skeletal conditions are included in the Outpatient Therapy Benefit (see below) and are covered at 80% after the in-network deductible. Combined coverage for these therapies is limited to a maximum of 20 visits per person per plan year. Office visits are covered with a $15 copay and x-rays are covered at 80% after the deductible is met.
- **Christian Science Treatment.** Treatment for a demonstrable illness or injury if provided in a facility accredited by the Commission for Accreditation of Christian Science Nursing Facilities/Organizations, Inc. or by a practitioner accredited by the Mother Church is covered at 80% after the in-network deductible. No benefits will be paid for the purpose of rest or study, for communication costs, or if the person requiring attention is receiving parallel medical care. Coverage is limited to a maximum cost to the plan of $1,000 per plan year. If required, this benefit may be extended for inpatient care for up to 60 days per plan year. Inpatient care must be precertified.

Services marked with a ◆ require precertification from Acordia National

- **Colorectal Cancer Screenings.** Routine screening to detect colorectal cancer is covered at 100% in-network with no deductible or coinsurance required. The related office visit expenses are subject to the applicable preventive care office visit copay. This benefit is covered as follows:
    - Fecal-occult blood test—1 in 12 months/age 50 and over
    - Flexible sigmoidoscopy—1 in 48 months/age 50 and over
    - Colonoscopy—1 in 24 months/high risk patients*; 1 in 10 years/age 50 and over
    - X-ray, barium enema—1 in 48 months/age 50 and over
    - X-ray, barium enema—1 in 24 months/high risk patients*

  *High risk is defined as a patient who faces high risk for colorectal cancer because of family history; prior experience of cancer or precursor neo-plastic polyps; history of chronic digestive disease condition (inflammatory bowel disease, Crohn's disease, ulcerative colitis); and presence of any appropriate recognized gene markers for colorectal cancer or other predisposing factors.
- **Cosmetic/Reconstructive Surgery.** Services provided after trauma, illness or disease to correct conditions resulting from the trauma, illness or disease are covered at 80% in-network after deductible is met.
- **Dental Services (accident-related only).** Services provided within six (6) months of an accident and required to restore tooth structures damaged due to that accident are covered at 80% after the deductible is met. The initial treatment must be provided within 72 hours of the accident. Biting and chewing accidents are not covered. Services provided more than six (6) months after the accident are not covered. Contact Acordia National for more information. For children under the age of 16, the six-month limitation may be extended if an approved treatment plan is provided to Acordia National within the initial six months.
- **Dental Services (impacted teeth)**. Medically necessary extraction of impacted teeth is covered at 80% in-network after deductible is met. Extractions for the purpose of orthodontia are not covered.
- **DEXA Scans.** Bone mass measurement by DEXA is limited to one scan every 24 months for members who meet one of the following criteria:

  1) Member has received results from a peripheral osteoporosis screen indicating moderate or high risk for osteoporosis; OR
  2) Member has documented clinical risk for osteoporosis.

  Diagnostic testing is covered at 80% after deductible has been met. Routine screening scans are not covered. Complete details of the DEXA scan payment policy are available on the PEIA website at www.wvpeia.com.
- **Diabetes Education**. Services of a diabetes education program that meets the standards of the American Diabetes Association are covered at 80% after in-network deductible is met. Coverage is limited to six (6) visits per patient: three visits with the dietitian and three visits with a registered nurse. Contact Acordia National for specific benefit limitations.
- ◆ **Durable Medical Equipment (DME) and Prosthetics**. Coverage for the initial purchase and reasonable replacement of standard implant and prosthetic devices, and for the rental or purchase (at the plan's discretion) of standard DME, when prescribed by a physician. Prosthetics and DME purchases of $1,000 or more, or rental for more than 3 months must be precertified by Acordia National. DME and prosthetics are covered at 80% after the deductible is met.
- **Emergency Services (including supplies).** Services received in an emergency room when the condition has been certified as an emergency are subject to a $25 copay and 20% coinsurance in-network. The copay and coinsurance amounts apply after the annual deductible has been met.

Services marked with a ◆ require precertification from Acordia National

- **Emergency Room Treatment.** Services received in an emergency room when the condition is determined to be a non-emergency are subject to a $50 copay and 20% coinsurance in-network. The copay and coinsurance amounts apply after the annual deductible has been met.
- ◆ **Home Health Services.** Intermittent health services of a home health agency when prescribed by a physician are covered at 80% after the deductible is met. Services must be provided in the home, by or under the supervision of a registered nurse. The home health services are covered only if they would otherwise have required confinement in a hospital or skilled nursing facility. If more than 3 visits are necessary, precertification is required.
- ◆ **Hospice Care.** When ordered by a physician; covered at 80% after the deductible is met.
- **Hypertension Screening.** The AccessWV Plan pays for diagnostic screening to determine if you are at risk for high blood pressure, heart disease or stroke. Benefits include coverage for an office visit, blood pressure check, and a blood chemistry profile. The office visit is subject to a $10 copay and the blood chemistry is covered at 80% after the deductible is met. The blood pressure check is included as part of the office visit. The plan will pay for this screening:
    a. One time between the ages of 20 and 30;
    b. Once every three years between ages 31 and 39; and
    c. Once every two years after age 40.
- **Immunizations.** For children through age 16. The plan covers immunizations and the associated office visit with no deductible, coinsurance, or copay required. Following is a list of immunizations and the ages at which PEIA covers them.
    a. Polio (IPV): At 2 months, 4 months, 6-18 months, and 4-6 years.
    b. Diphtheria-Tetanus-Pertussis (DTaP): At 2 months, 4 months, 6 months, 15-18 months, and 4-6 years.
    c. Tetanus-Diphtheria (Td): At 11-16 years.
    d. Measles-Mumps-Rubella (MMR): At 12-15 months and EITHER 4-6 years OR 11-12 years.
    e. Haemophilus Influenzae type b (Hib): At 2 months, 4 months, 6 months, and 12-15 months; OR 2 months, 4 months, and 12-15 months, depending on the vaccine type.
    f. Hepatitis B: At birth-2 months, 1-4 months, and 6-18 months. If missed, get 3 doses starting at age 11 years.
    g. Chicken Pox (VZV): At 12-18 months. If missed, get between ages 11 and 12 years.
    h. Hepatitis A: At 24 months-12 years in selected areas.
    i. Pneumococcal disease (PrevnarTM): At 2 months, 4 months, 6 months, and 12-15 months. If missed, talk to your health care provider. Also see "Well Child Care" on page 31.
    j. For adults and children over age 16. The plan covers immunizations as recommended by the American Academy of Family Physicians at 100% in-network. The associated office visit is subject to the applicable copay. Other immunizations covered with 20% coinsurance after the deductible is met.
- ◆ **Inpatient Hospital and Related Services.** Confinement in a hospital including semi-private room, special care units, confinement for detoxification, and related services and supplies during the confinement are covered at 80% after the deductible is met. In addition to the penalties discussed on page 24, all out-of-network inpatient admissions are subject to a $500 copay per admission.

Services marked with a ◆ require precertification from Acordia National

- **Inpatient Medical Rehabilitation Services.** When ordered by a physician, coverage is subject to 20% coinsurance after the deductible is met and is limited to 150 days per plan year. In addition to the penalties discussed on page 24, all out-of-network inpatient admissions are subject to a $500 copay per admission.
- **Mammogram.** An annual routine mammogram to detect breast abnormalities is covered at 100% in-network with no coinsurance or deductible required. The related office visit expenses are subject to the applicable copayment. When billed with a medical diagnosis (instead of as a screening test), it is considered a diagnostic test, and the deductible and 20% coinsurance will apply.
- **Massage Therapy.** Services of a licensed massage therapist for treatment of neuromuscular-skeletal conditions are covered under the Outpatient Therapy Benefit when ordered by a physician. Covered at 80% after the deductible is met. Combined coverage for these therapies is limited to a maximum of 20 visits per person per plan year.
- **Mastectomy.** If you are receiving benefits in connection with a mastectomy due to cancer and elect breast reconstruction in connection with such benefits, you are entitled to the following procedures:
    a. Reconstruction of the breast on which the mastectomy was performed;
    b. Reconstructive surgery of the other breast to present a symmetrical appearance; and
    c. Prostheses and coverage for physical complications at all stages of the mastectomy procedure including lymphedas.
- **Maternity Services.** See "Maternity Benefits" on page 32 for details.
- ◆ **Mental Health Services.**
    a. Inpatient and partial hospitalization day programs for mental health, chemical dependency and substance abuse services are limited to a maximum of 30 days per patient, per plan year. For outpatient partial/day programs, two (2) outpatient days will be counted as one (1) inpatient day when applying the 30-day maximum. Catastrophic cases will be assigned to a nurse case manager. For these extreme medical conditions, the case manager may, based on medical documentation, recommend additional treatment. Precertification is required These services are covered at 80% after the deductible is met. Out-of-network inpatient admissions are subject to a $500 copay per admission.
    b. Outpatient mental health, chemical dependency and substance abuse services are limited to a maximum of 20 visits per patient per plan year for short-term individual and/or group outpatient mental health and chemical dependency services. This benefit includes evaluation and referral, diagnostic, therapeutic, and crisis intervention services performed on an outpatient basis (includes a physician's office). Catastrophic cases will be assigned to a nurse case manager. For these extreme medical conditions, the case manager may, based on medical documentation, recommend additional treatment beyond the 20 visits. This benefit is covered at 80% after the deductible is met.
- **MRA.** Magnetic Resonance Angiography services when performed on an outpatient basis are covered at 80% after the deductible is met.
- ◆ **MRI.** Magnetic Resonance Imaging services when performed on an outpatient basis must be precertified by Acordia National and are covered at 80% after the deductible is met.
- ◆ **Neuromuscular Stimulators and Bone Growth Stimulators** when criteria are met are covered at 80% after the deductible is met.

Services marked with a ◆ require precertification from Acordia National

- **Oral Surgery.** Only covered for extraction of impacted teeth, orthognathism and medically necessary ridge reconstruction at 80% after the deductible is met. Preauthorization is recommended for orthognathic procedures and ridge reconstruction procedures. Dental implants are not covered.
- **Organ Transplants**. See "Organ Transplant Benefits" on page 33 for more details.
- **Outpatient Diagnostic and Therapeutic Services**. Laboratory, diagnostic tests, and therapeutic treatments, when ordered by a physician, are covered at 80% after the deductible is met.
- ◆ **Outpatient Surgery**. This benefit is subject to a $50 copayment and 20% coinsurance in-network when performed in a hospital or alternative facility. When performed in a physician's office, the $50 copay does not apply. Certain procedures require precertification.
- **Outpatient Therapies.** Coverage for the following outpatient therapies are combined into one benefit and are available at 80% after the deductible is met: physical, massage, occupational, speech, and vision therapies, acupuncture and chiropractic treatment. The benefit is limited to a maximum of 20 visits per person per plan year for all of the therapies combined. Case management is required for more than 20 visits.
    a. **Acupuncture.** Services of a licensed acupuncturist for treatment of medical conditions are covered at 80% after the in-network deductible. Contact Acordia National for specific benefit limitations. Office visits are covered with a $15 copay and treatments are covered at 80% after the deductible is met.
    b. **Chiropractic Treatment**. Services of a chiropractor for treatment of neuromuscular-skeletal conditions are included in the Outpatient Therapies benefit (see above) and are covered at 80% after the deductible is met. Office visits are subject to the $15 copay and x-rays are covered at 80% after deductible is met.
    c. **Massage Therapy.** When ordered by a physician, services of a licensed massage therapist are covered at 80% after the deductible is met.
    d. **Occupational Therapy.** When ordered by a physician, this benefit is included in the Outpatient Therapies benefit and is covered at 80% after the deductible is met.
    e. **Physical Therapy.** When ordered by a physician, this benefit is included in the Outpatient Therapies benefit and is covered at 80% after the deductible is met.
    f. **Speech Therapy**. When ordered by a physician, this benefit is included in the Outpatient Therapies benefit and is covered at 80% after the deductible is met.
    g. **Vision Therapy.** Contact Acordia National for preauthorization of these services. This benefit is included in the Outpatient Therapies benefit and is covered at 80% after the deductible is met.
- ◆ **Pain Management Services.** Covered at 80% after the deductible is met. Only Multidisciplinary Pain Management services require precertification.
- **Pap Smear.** An annual Pap smear and the associated office visit to screen for cervical abnormalities are covered. The Pap smear is covered at 100% in-network with no deductible or coinsurance, and the office visit is subject to a $10 preventive care office visit copay. When billed with a medical diagnosis (instead of as a screening test), it is considered a diagnostic test, and the deductible and 20% coinsurance will apply.
- **Periodic Physicals (for Adults).** AccessWV Plan covers a routine physical exam once every two years for adults age 18 and over. Routine physicals are subject to a $10 copay per visit. Exams may be provided more often if the patient's medical history indicates a need. The $10 copay also applies to routine preventive care for adolescents age 16 through 17. See "Well Child Care" below.

Services marked with a ◆ require precertification from Acordia National

- **Physician's Office Visits (treatment for illness, injury, or medical condition).** These visits are subject to a $15 copay for in-network services.
- **Professional Services** of a physician or other licensed provider for treatment of an illness, injury or medical condition. Includes outpatient and inpatient services (such as surgery, anesthesia, radiology, and office visits). Office visits for preventive or specialty care are subject to the applicable copay (see above) while other physician services are covered at 80% after the deductible is met.
- **Prostate Cancer Screening.** Coverage is provided for an annual office visit and exam to detect prostate cancer in men age 50 and over with a $10 preventive care office visit copay. The PSA blood test associated with this screening is covered at 100% with no deductible or coinsurance in-network.
- **Second Surgical Opinions.** Office visits for second surgical opinions are subject to a $15 copay per visit. Second surgical opinions are paid at 100% if required by Acordia National.
- ◆ **Skilled Nursing Facility Services.** Confinement in a skilled nursing facility including semi-private room, related services and supplies is covered at 80% after the deductible is met. Confinement must be prescribed by a physician in lieu of hospitalization. Coverage is limited to 100 days per plan year. In addition to the coinsurance discussed on page 21, all out-of-network inpatient admissions are subject to a $500 deductible per admission.
- **Well Child Care**. For children through age 16, the plan covers routine office visits for preventive care as recommended by the American Academy of Pediatrics. These visits are covered at 100% of allowed charges and are not subject to copay or coinsurance or deductible. Covered preventive care includes, but is not limited to:
    a. height and weight measurement;
    b. blood pressure check;
    c. vision and hearing screening;
    d. developmental/behavioral assessment; and
    e. physical examination.

  There is a $10 copay for routine preventive care office visits for adolescents over the age of 16. Well Child Care office visits are recommended by the American Academy of Pediatrics at the following ages:
    a. Infancy: 1 month, 2 months, 4 months, 6 months, 9 months and 12 months.
    b. Early childhood: 15 months, 18 months, 24 months, 3 years and 4 years.
    c. Late childhood: 5 years, 6 years, 8 years, 10 years and 12 years.
    d. Adolescence: 14 years and 16 years.

Services marked with a ◆ require precertification from Acordia National

Special Benefits

MATERNITY BENEFITS

AccessWV provides coverage for maternity-related professional and facility services, including prenatal care, midwife services and birthing centers. Maternity-related services are covered only for the policyholder or the policyholder's enrolled spouse.

Contact Acordia National at 1-866-864-6142 during the first trimester of your pregnancy or as soon as your pregnancy is confirmed. Acordia can assist you in identifying possible factors that may put you at risk for premature labor and delivery. If risk factors are identified, Acordia nurses will work with you and your doctor to help safeguard the health of mother and baby. You will need to contact Acordia National anytime you are admitted to the hospital during your pregnancy and within 48 hours of your admission for delivery, even if you are discharged in less than 48 hours.

Payment Level

Maternity services for routine prenatal care, delivery and follow-up are paid at 100% of allowed charges under a global fee after the deductible has been met. An obstetrical profile and one ultrasound are also paid at 100% of allowed charges after the deductible is met. Other maternity services, including hospital charges and anesthesia services, are paid at the regular AccessWV level of 80% of allowed charges after the deductible is met, for in-network care.

Maternity Pre-Payment Benefit

If your attending provider requests a deposit for maternity care before delivery, AccessWV will make an advance payment of up to $500. This will be deducted from the global fee paid after delivery. To receive this benefit, please contact Acordia National and request a Maternity Pre-Payment form.

High Risk Birth Score Program

For infants identified at birth as being at risk for health problems, AccessWV will pay for six office visits between the age of two weeks and 24 months in addition to AccessWV's regular Well Child Care benefits. These additional visits are paid at 100% of allowed charges and are not subject to the deductible. Acordia National will notify those families who qualify for this benefit.

Enrolling Your Newborn

Please be sure you remember to add your newborn to your coverage by completing a Change Form. Request a Change Form by calling PEIA. See the Eligibility Section on page 10 for more information.

Nursery Charges

If the baby is enrolled for coverage under AccessWV, charges for the newborn nursery care will be paid in the baby's name. If the baby is not enrolled for coverage under AccessWV, charges for a normal, healthy newborn's nursery care will be covered as part of the mother's maternity benefit. If the newborn is covered under another plan, coordination of benefits rules will apply.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

AccessWV's maternity benefit meets or exceeds all of the requirements of the Newborns' and Mothers' Health Protection Act. Under federal law, health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by Caesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

ORGAN TRANSPLANT BENEFITS

Organ transplants are covered when deemed medically necessary and non-experimental. They are subject to precertification and case management by Acordia. You should contact Acordia as soon as you learn that you or a member of your family covered by AccessWV may need a transplant.

All transplants require precertification for determination of medical necessity. When it is determined by your physician that you are a potential candidate for any type of transplant, Acordia should be contacted immediately. They will identify Centers of Excellence available to you through the PEIA Transplant Network with experience in the specific type of transplant you require. You should advise your physician that Acordia needs to coordinate the care from the initial phase when considering a transplant procedure, initial workup for transplant through the performance of the procedure and the care following the actual transplant.

Any services and supplies that are required for donor/procurement as a result of a surgical transplant procedure for a member will be covered. Benefits for such charges, services and supplies are not provided under AccessWV if benefits are provided under another group plan or any other group or individual contract or any arrangement of coverage for individuals in a group (whether on an insured or uninsured basis), including any prepayment coverage. Testing for persons other than the chosen donor is not covered.

Organ Transplant Network (OTN)

AccessWV uses network providers for organ transplant services. This helps to control health care costs for both you and the plan. AccessWV uses a specialized transplant network called LifeTrac, as well as special contracts with West Virginia University hospitals for bone marrow transplants, and with Charleston Area Medical Center for kidney transplants. Acordia will work with patients and physicians to determine which network facility best serves the patient's medical needs.

OTN Benefits

Reduced Costs: Once the annual deductible and out-of-pocket maximum have been met, you will pay no more coinsurance on the negotiated fees for pre-transplant, transplant, and follow-up services. Copayments for office visits and other services described on pages 17-18 will still apply.

Travel Allowance:

Because network facilities may be located some distance from the patient's home, benefits include up to $5,000 for patient travel, lodging and meals. A portion of this benefit is available to cover the travel, lodging and meals for a member of the patient's family or a friend providing support. Receipts are required for payment; mileage and cost estimates are not acceptable.

Medical Case Management:

Acordia National offers support and assistance in evaluating treatment options and referrals to the prescription drug administrator. Management begins early when the potential need for a transplant is identified, and continues through the surgery and follow-up. When the need for a transplant presents itself, call Acordia National at 1-888-440-7342 or 1-304-353-7820. You should contact Acordia as soon as you learn that you or a member of your family covered by AccessWV may need a transplant. All transplants must be precertified through Acordia.

Out-of-Network Organ Transplant:

For patients who choose to use a non-network facility for transplant services, there will be a $10,000 deductible applied to the cost of the hospital admission; this is in addition to your annual deductible and out-of-pocket maximum. This deductible will be waived only if treatment at a non-network facility is approved as medically necessary in advance by Acordia. No travel benefits will be provided for out-of-network transplants (except medically necessary ambulance transport).

Transplant-Related Prescription Drugs

AccessWV covers transplant-related immunosuppressant prescription drugs at 100%, after you have met your prescription drug deductible (if they are filled at a network pharmacy) up to the annual pharmacy benefit maximum or the combined medical and pharmacy lifetime maximum which ever occurs first. These are covered through the Prescription Drug Plan and processed by the prescription drug administrator, Express Scripts, Inc. Details of the Prescription Drug Plan are found in the "Prescription Drug Benefit" section starting on page 38. Medical case management of transplant patients includes referral to the prescription drug administrator for waiver of copayment on transplant-related immunosuppressant drugs. Acordia will make arrangements with the prescription drug administrator to waive copayments on drugs used to sustain the transplant.

WHAT IS NOT COVERED

Some services are not covered by AccessWV regardless of medical necessity. Specific exclusions are listed below. If you have questions, please contact Acordia at 1-866-864-6142.

The following services are not covered:

1. Aqua therapy.
2. Biofeedback, except in the case of mental health services.
3. Birth control drugs, devices, and services for dependent children.
4. Breast pumps.
5. Chemical dependency treatments when a patient leaves the hospital or facility against medical advice.
6. Coma stimulation.
7. Cosmetic or reconstructive surgery when not medically required as the result of accidental injury or disease, or unless the surgery is performed to correct birth defects. Services resulting from or related to these excluded services also are not covered.
8. Custodial care, intermediate care (such as residential treatment centers), domiciliary care, respite care, rest cures, or other services primarily to assist in the activities of daily living, or for behavioral modification.
9. Dental services including dental implants, routine dental care, x-rays, treatment of cysts or abscesses associated with the teeth, or any other dentistry and dental procedures.
10. Daily living skills training.
11. Duplicate testing, interpretation or handling fees.
12. Education, training and/or cognitive services, unless specifically listed as covered services.
13. Elective abortions.
14. Expenses for which the patient is not responsible, such as patient discounts and contractual discounts.
15. Experimental, investigational or unproven services, unless pre-approved by Acordia.
16. Fertility drugs and services.
17. Foot care. Routine foot care including:
    a. Removal in whole or in part of: corns, calluses (thickening of the skin due to friction, pressure, or other irritation), hyperplasia (overgrowth of the skin), or hypertrophy (growth of tissue under the skin);
    b. Cutting, trimming, or partial removal of toenails;
    c. Treatment of flat feet, fallen arches, or weak feet; and
    d. Strapping or taping of the feet.
18. Genetic testing.
19. Glucose monitoring devices, except Bayer Ascensia models covered under the prescription drug benefit.
20. Homeopathic medicine.
21. Hospital days associated with non-emergency weekend admissions or other unauthorized hospital days prior to scheduled surgery.
22. Hypnosis.
23. Incidental surgery performed during medically necessary surgery.
24. Infertility and sterility services of in vitro fertilization and gamete intrafallopian transfer (GIFT), embryo transport, surrogate parenting, and donor semen, any other method of artificial insemination, and any other related services.
25. Maintenance chiropractic services.
26. Marriage counseling.
27. Medical equipment, appliances or supplies of the following types:
    a. augmentative communication devices.
    b. bathroom scales.
    c. educational equipment.
    d. environmental control equipment such as air conditioners, humidifiers or dehumidifiers, air cleaners or filters, portable heaters, or dust extractors.
    e. equipment or supplies which are primarily for patient comfort or convenience, such as bathtub lifts or seats; massage devices; elevators; stair lifts; escalators; hydraulic van or car lifts; orthopedic mattresses; walking canes with seats; trapeze bars; child strollers; lift chairs; recliners; contour chairs; adjustable beds; or tilt stands.
    f. equipment which is widely available over the counter such as wrist stabilizers and knee supports.
    g. exercise equipment such as exercycles; parallel bars; walking, climbing or skiing machines.
    h. hearing aids.
    i. hygienic equipment such as bed baths, commodes, and toilet seats.
    j. motorized scooters.
    k. nutritional supplements, food liquidizers or food processors.
    l. orthopedic shoes, unless attached to a brace.
    m. over-the-door and/or gravity traction.
    n. professional medical equipment such as blood pressure kits or stethoscopes.
    o. supplies such as tape, alcohol, Q-tips/swabs, gauze, bandages, thermometers, aspirin, diapers (adult or infant), heating pads or ice bags.
    p. vibrators.
    q. whirlpool pumps or equipment.
    r. wigs or wig styling.
28. Medical rehabilitation and any other services that are primarily educational or cognitive in nature.
29. Mental health or chemical dependency services to treat mental illnesses which will not substantially improve beyond the patient's current level of functioning.
30. Optical services. Routine eye examinations, refractions, eye glasses, contact lenses and fittings. Glasses and/or contact lenses following cataract surgery are not covered.
31. Orientation therapy.
32. Orthodontia services.
33. Orthotripsy.
34. Physical examinations and routine office visits except those covered under the Periodic Physicals benefit.
35. Personal comfort and convenience items or services (whether on an inpatient or outpatient basis) such as television, telephone, barber or beauty service, guest services, and similar incidental services and supplies, even when prescribed by a physician.
36. Physical conditioning and work hardening. Expenses related to physical conditioning programs and work hardening such as athletic training, body building, exercise, fitness, flexibility, diversion, or general motivation.

37. Physical, psychiatric, or psychological examinations, testing, or treatments not otherwise covered under the plan, when such services are:
    - conducted for purposes of medical research;
    - for participation in athletics;
    - needed for marriage or adoption proceedings;
    - related to employment;
    - related to judicial or administrative proceedings or orders;
    - to obtain or maintain a license or official document of any type; or
    - to obtain or maintain insurance.
38. Pregnancy-related conditions for dependent children.
39. Provider charges for phone calls, prescription refills, or physician-to-patient phone consultations.
40. Radial keratotomy and other surgery to correct vision.
41. Reversal of sterilization and associated services and expenses.
42. Safety devices. Devices used specifically for safety or to affect performance primarily in sports-related activities.
43. Screenings, except those specifically listed as covered benefits.
44. Services rendered by a provider with the same legal residence as a member, or who is a member of the policyholder's family. This includes spouse, brother, sister, parent, or child.
45. Services rendered outside the scope of a provider's license.
46. Sex transformation operations and associated services and expenses.
47. Skilled nursing services provided in the home, except intermittent visits covered under the Home HealthCare benefit.
48. Stimulation therapy.
49. Take-home drugs provided at discharge from a hospital.
50. TMJ. Treatment of temporomandibular joint (TMJ) disorders. Including intraoral prosthetic devices or any other method of treatment to alter vertical dimension or for temporomandibular joint dysfunction not caused by documented organic disease or acute physical trauma.
51. The difference between private and semi-private room charges.
52. Therapy and related services for a patient showing no progress.
53. Therapies rendered outside the United States that are not medically recognized within the United States.
54. Transportation other than medically necessary emergency ambulance services, or as approved under the Organ Transplant Network benefit.
55. War-related injuries or illnesses. Treatment in a state or federal hospital for military or service-related injuries or disabilities.
56. Weight loss. Health services and associated expenses intended primarily for the treatment of obesity and morbid obesity, including wiring of the jaw, weight control programs, weight control drugs, screening for weight control programs, and services of a similar nature, except those services provided through a pilot program offered by PEIA.
57. Work-related injury or illness.

Prescription Drug Benefit

Along with your medical coverage, you also have prescription drug coverage. The prescription drug program is administered by Express Scripts, Inc (ESI). There are three parts to the program:

- The Retail Pharmacy Program gives you access to local participating pharmacies to get your prescriptions filled.
- The Express Scripts Mail Service Pharmacy Program lets you order your prescriptions through the mail, saving you time and money by having your maintenance medications delivered to your door.
- The Curascript Specialty Medication Program provides your common specialty medications through the mail, saving you time by having your medications delivered to your door or to your physician's office.

Your prescription drug benefits pay for a wide range of medications, with differing copay depending on where you purchase those drugs, and how large a supply you buy.

WHAT YOU PAY

Pharmacy Deductible

During any plan year, if you or your eligible dependents incur expenses for covered prescription drugs, you must meet a deductible before the plan begins to pay. The phamacy deductibles for single and family coverage are shown in the Summary of Benefits.

You will pay the deductible amount before the plan begins to pay.

The family deductible is twice the single deductible. The family deductible is divided up among the family members. No one member of the family will pay more than the single deductible. Once that person has met the single deductible, the plan will begin paying on that person. When another member of the family meets the single deductible, then the plan will begin paying on the entire family. Alternatively, all members of the family may contribute to the family deductible with no one person meeting the single deductible; once the family deductible is met, the plan pays on all members of the family. After you meet your deductible, you will pay copays based on the amount and type of drug you're taking. The chart on page 40 shows the copays.

Copays

Under your prescription drug plan, once you meet your deductible, you pay a copay to obtain drugs. Copays are the portion of the cost that, under your plan, you are required to pay per new or refill prescription untill your out-of-pocket maximum is met. The rest of the cost is paid by AccessWV. Several factors determine your copay.

Generic Drugs

The brand name of a drug is the product name under which the drug is advertised and sold. Generic medications have the same active ingredients and are subject to the same rigid U.S. Food and Drug Administration (FDA) standards for quality, strength and purity as their brand-name counterparts. Generic drugs usually cost less than brand-name drugs. Please ask your doctor to prescribe generic drugs whenever possible.

West Virginia Preferred Drug List (WVPDL) (Formulary)

The West Virginia Preferred Drug List (WVPDL) is a list of carefully selected medications that can assist in maintaining quality care while providing opportunities for cost savings to AccessWV. Under this program, your plan requires you to pay a lower copay for medications on the WVPDL and a higher copay for medications not on the WVPDL. By asking your doctor to prescribe WVPDL medications, you can maintain high-quality care while you help to control rising health-care costs.

Here's how the copay structure works:

- Highest Copay: You will pay the highest copay for brand-name drugs that are not listed on the WVPDL.
- Middle Copay: You will pay a mid-level copay for brand-name drugs that are listed on the WVPDL.
- Lowest Copay: You will pay the lowest copay for all generic drugs. Generic drugs are subject to the same rigid U.S. Food and Drug Administration standards for quality, strength and purity as their brand-name counterparts. Generic drugs usually cost less than brand-name drugs. Please ask your doctor to prescribe generic medications for you whenever possible.

Sometimes your doctor may prescribe a medication to be "dispensed as written" when a WVPDL brand name or generic alternative drug is available. As part of your plan, an Express Scripts pharmacist or your retail pharmacist may discuss with your doctor whether an alternative formulary or generic drug might be appropriate for you. Your doctor always makes the final decision on your medication, and you can always choose to keep the original prescription at the higher copay.

Drugs on the WVPDL are determined by the Express Scripts Pharmacy and Therapeutics Committee. The committee, made up of physicians, meets quarterly to review the medications currently on the Formulary, and to evaluate new drugs for addition to the Formulary. The Formulary may change periodically, based on the recommendations adopted by the committee.

If you have any questions about the copay structure or about your WVPDL, please call Express Scripts Member Services at 1-877-256-4680.

Copays		
Generic	In-Network	$5
	Out-of-Network	$5 + $3 Out-of-Network copay
Formulary brand necessary	In-Network	$15
	Out-of-Network	$15 + $3 Out-of-Network copay
Brand requested by patient	In-Network	$5 + full cost difference from generic
	Out-of-Network	$5 + $3 Out-of-Network copay + full cost difference from generic
Non-Formulary	In-Network	$30
	Out-of-Network	$30 + $3 Out-of-Network copay
Common speciality medications	CuraScript only	$50

BENEFIT LIMITS

Pre-Existing Condition Six-Month Waiting Period

If you have a pre-existing condition that requires a six-month waiting period before claims will be paid for your condition, your pharmacist must receive a prior authorization before any prescription can be filled. This may require a 24-hour wait before the pharmacist receives the approval or denial. If coverage is denied due to the waiting period, you will be required to pay the full amount for the prescription. This applies only to prescriptions that relate to the pre-existing condition. New prescriptions for other illness or injury will be paid as outlined.

Pharmacy Out-of-Pocket Maximum

AccessWV has a pharmacy out-of-pocket maximum of $2,000 for single coverage and $4,000 for family coverage. The out-of-pocket maximum only includes actually copays, not deductibles or other charges and is separate from your medical out-of-pocket maximum (see page 19).

Once you have met the out-of-pocket maximum, AccessWV will cover the entire cost of your prescriptions for the balance of the plan year until you reach the annual benefit maximum of $25,000 per member per year.

Annual Benefit Maximum

AccessWV has an annual benefit limit of $25,000 per member for each plan year for pharmacy benefits. Benefits paid under the Medical Plan have $200,000 per member limit per year. This limit includes only the actual dollars paid by the plan on behalf of the member.

Once the plan expends either annual benefit limit, the member must continue to pay premiums to maintain membership with AccessWV. If the member chooses to cancel coverage, he or she must wait 12 months after termination of coverage to re-apply to AccessWV and will be subject to a waiting period for pre-existing conditions.

Lifetime Maximum

AccessWV will pay a maximum of $1,000,000 in benefits per person during each member's lifetime. Benefits paid under the Prescription Drug Plan are included in this maximum. Once this maximum is reached,the member's coverage will be terminated by the Plan. If the member is the policyholder, coverage will be terminated for the policyholder and dependents.

GETTING YOUR PRESCRIPTIONS FILLED

Using a Retail Network Pharmacy

Express Scripts has a nationwide network of pharmacies. To get a prescription filled, simply present your medical/prescription drug ID card at a participating Express Scripts pharmacy. You can purchase both acute and maintenance medications at an Express Scripts network pharmacy. Your ID card contains personalized information that identifies you as an AccessWV member, and ensures that you receive the correct coverage for your prescription drugs. If you use an Express Scripts pharmacy, you do not have to file a claim form. The pharmacist will file the claim for you online, and will let you know your portion of the cost.

If you use a network pharmacy and choose not to have the pharmacist file the claim for you online, you will pay 100% of the prescription price at the time of purchase. You may submit the receipt with a completed claim form to Express Scripts for reimbursement. The prescription receipt must be attached to the form. You will usually be reimbursed within 21 days from receipt of your claim form. You will be reimbursed the amount PEIA would have paid, less your required copay, your deductible (if applicable), and a $3 fee. This reimbursement may be less than you paid for the prescription.

If you need claim forms, call Express Scripts Member Services at 1-877-256-4680 or visit their website at www.express-scripts.com.

To find the participating pharmacies nearest you, call Express Scripts Member Services at 1-877-256-4680 and use the voice-activated Pharmacy Locator System. If you have Internet access, you can find a pharmacy online at www.express-scripts.com.

Using the Retail Maintenance Network

If you take a drug on a long-term basis, you may be able to purchase a 90-day supply of that drug if it is on the maintenance list (see the Maintenance Drug List). AccessWV offers a Retail Maintenance Network of pharmacies that will fill your 90-day prescription for just two copays. You can buy two months and get one month free. Check with your local pharmacist to verify participation.

Using Non-Network Pharmacies

If you use a non-participating pharmacy, you will pay 100% of the prescription price at the time of purchase, and submit a completed claim form to Express Scripts. The prescription receipt must be attached to the form. You will usually be reimbursed within 21 days from receipt of your claim form. You will be reimbursed the amount AccessWV would have paid at a participating pharmacy, less your required copay, your deductible (if applicable), and a $3 fee. This reimbursement may be less than you paid for the prescription.

If you need claims forms, call Express Scripts Member Services at 1-877-256-4680 or visit their website at www.express-scripts.com.

Using the Express Scripts Mail Service Pharmacy Program

Express Scripts provides a convenient mail service pharmacy program for AccessWV members. You may use the mail service pharmacy if you're taking medication to treat an ongoing health condition, such as high blood pressure, asthma, or diabetes.

When you use the mail service pharmacy, you can order up to a 90-day supply of a medication on the maintenance list, as prescribed by your doctor, and pay only two copays. Express Scripts' licensed professionals fill every prescription following strict quality and safety controls. If you have questions about your prescription, registered pharmacists are available around the clock to consult with you.

Maintenance Drug Copay	
In-Network	90-day supply for 2 month copay in mail order program or Retail Maintenance Network*
Out-of-Network	No discount available

*Some restrictions apply.

New Prescriptions and the Mail Service Pharmacy

If you want to use the mail service pharmacy the first time you are prescribed a medication that you will need on an ongoing basis, ask your doctor for two prescriptions: the first for a 14-day supply to be filled at a participating retail pharmacy; the second, for up to a 90-day supply, to be filled through the mail service pharmacy. There are several ways to submit your mail service prescriptions. Just follow the steps below. Some restrictions apply.

1. Ordering new prescriptions. Ask your doctor to prescribe your medication for up to a 90-day supply for maintenance medications, plus refills if appropriate. Mail your prescription and required copay along with an order form in the envelope provided. Or ask your doctor to fax your order to 1-800-636-9494. You will need to give your doctor your member ID number located on your ID card.
2. Refilling your medication. A few simple precautions will help ensure you don't run out of your prescription. Remember to reorder on or after the refill date indicated on the refill slip. Or reorder when you have less than 14 days of medication left.
    - Refills online: Log on to Express Scripts' website at www.express-scripts.com. Have your member ID number, the prescription number (it's the 9-digit number on your refill slip), and your credit card ready when you log on.
    - Refills by phone: Call 1-877-256-4680 and use the automated refill system. Have your member ID number, refill slip with the prescription number, and your credit card ready.
    - Refills by mail: Use the refill and order forms provided with your medication. Mail them with your copay.
3. Delivery of your medication. Prescription orders receive prompt attention and, after processing, are usually sent to you by U.S. mail or UPS within two weeks. Your enclosed medication will include instructions for refills, if applicable. Your package may also include information about the purpose of the medication, correct dosages, and other important details.
4. Paying for your medication. You may pay by check, money order, VISA, MasterCard, Discover or American Express. Debit cards are not accepted for payment.

Please note: The pharmacist's judgment and dispensing restrictions, such as quantities allowable, govern certain controlled substances and other prescribed drugs. Federal law prohibits the return of any dispensed prescription medicines.

PRIOR AUTHORIZATION

Your prescription drug program provides coverage for some drugs only if they are prescribed for certain uses and amounts, so those drugs require prior authorization for coverage. Prior authorization is handled by the Rational Drug Therapy Program (RDT). If your medication must be authorized, your pharmacist or physician can initiate the review process for you. The prior authorization process is typically resolved over the phone; if done by letter it can take up to two business days. If your medication is not approved for plan coverage, you will have to pay the full cost of the drug.

AccessWV will cover, and your pharmacist can dispense, up to a five-day supply of a medication requiring prior authorization for the applicable copayment. This policy applies when your doctor is either unavailable or temporarily unable to complete the prior authorization process promptly. Prior authorizations may be approved retroactively for up to 30 days to allow time for the physician to work with and provide documentation to RDT. If the prior authorization is ultimately approved, your pharmacist will be able to dispense the remainder of the approved amount with no further copay for that month's supply if you have already paid the full copay.

The medications listed below require prior authorization:

1. becaplermin (Regranex®)
2. Botox®*
3. Brand-name medically necessary prescriptions. If the medication your doctor prescribes is a multi-source drug (that is, more than one manufacturer markets the drug), and there is an FDA-approved—or "A-B-rated"—generic on the market, then PEIA will pay only for the generic version, unless your physician provides medical justification for coverage of the brand-name drug. If prior authorization is granted, these drugs will be covered as non-preferred brand-name drugs.
4. ciclopirox (Penlac®)
5. erythroid stimulants (Epogen®, Procrit®, Aranesp®)*
6. fentanyl (Actiq® and Duragesic®)
7. fluconazole (Diflucan®)
8. growth hormones*
9. itraconazole (Sporanox®)
10. legend oral contraceptives for dependents (covered for treatment of medical conditions only)
11. leuprolide (Lupron®, Lupron Depot®)*
12. modafinil (Provigil®) for adults (for pharmacy benefits, PEIA defines "adults" as 19 years of age and older.)
13. Myobloc®*
14. oxycodone hydrochloride (Oxycontin®)
15. tazarotene (Tazorac®)
16. terbinafine (Lamisil®)
17. teriparatide (Forteo®)*
18. tretinoin cream (e.g. Retin-A) for individuals 27 years of age or older
19. topiramate (Topamax®)
20. vacation supplies of medication for foreign travel (allow 7 days for processing)
21. voriconazole (VFEND®)
22. zonisamide (Zonegran®)

** These drugs must be purchased through the Common Specialty Medications Program. See information later in this section.*

This list is subject to change during the plan year if circumstances arise which require adjustment. Changes will be communicated to members prior to implementation. The changes will be included in the next edition of the Policy.

DRUGS WITH SPECIAL LIMITATIONS

Step Therapy

Step Therapy promotes appropriate utilization of first-line drugs and/or therapeutic categories. Step Therapy requires that participants receive one or more first-line drug(s), as defined by program criteria before prescriptions are covered for second-line drugs in defined cases where a step approach to drug therapy is clinically justified.

To promote use of cost-effective first-line therapy, AccessWV uses step therapy in the following therapeutic classes:

- Angiotensin-Converting Enzyme (ACE) Inhibitors (Accuretic®, Accupril®, Aceon®, Altace®, Capoten® Capozide®, Lexxel®, Lotesin/HCT®, Lotrel®, Mavik®, Monopril/HCT®, Prinivil®, Prinizide®, Tarka®, Uniretic®, Univasc®, Vasotec®, Vaseretic®)
- Angiotensin II Receptor Antagonists (Atacand/HCT®, Teveten/HCT®, Avapro®, Cozaar®, Benicar/HCT®, Micardis/HCT®, Diovan/HCT®, Avalide®, Hyzaar®)
- Disease-Modifying Antirheumatic Drugs (e.g., Enbrel®, Kineret®, Humira®) [Must be purchased through the Common Specialty Medication Program. See information later in this section.]
- Inspra®
- Leukotriene Inhibitors (e.g., Accolate®, Singulair®)
- Non-Steroidal Anti-Inflammatory Drugs (brand-name NSAID e.g., Celebrex®, Arthrotec®, Mobic®),
- Proton Pump Inhibitors (e.g., omeprazole, Prilosec®, Prevacid®, Nexium®, Aciphex®, Protonix®),
- Selective Serotonin Reuptake Inhibitors (e.g., Celexa®, Lexapro®, Luvox®, Paxil®, Paxil CR®, Prozac®, Prozac Weekly®, Zoloft®),
- Straterra®, and
- Xopenex®

This list is subject to change during the plan year if circumstances arise which require adjustment. Changes will be communicated to members prior to implementation. The changes will be included in the next edition of the Policy.

Quantity Limits

Under AccessWV Prescription Drug Program, certain drugs have preset coverage limitations (quantity limits). Quantity limits ensure that the quantity of units supplied in each prescription remains consistent with clinical dosing guidelines and AccessWV's benefit design. Quantity limits encourage safe, effective and economic use of drugs and ensure that members receive quality care. Select medications from the quantity limit list are provided on the following page. If you are taking one of the medications listed below and you need to get more of the medication than the plan allows, ask your pharmacist or doctor to call RDT to discuss your refill options.

1. Anzemet®, Emend®, Kytril®, Zofran® coverage limitations:
   - Anzemet® is limited to 1 tablet per prescription
   - Emend® 80mg is limited to 2 capsules per prescription.
   - Emend® 125mg is limited to 1 capsule per prescription.
   - Emend® Tri-fold Pack is limited to 1 package per prescription.
   - Kytril® is limited to 2 tablets per prescription
   - Zofran® 24 mg is limited to 1 tablet per prescription
   - Zofran® 4 mg and 8 mg are limited to 12 tablets per prescription
   - Zofran® Solution is limited to 3 bottles per prescription
   - Diflucan® 150 mg is limited to two tablets per prescription.
2. Migraine medications. Coverage is limited to quantities listed in the chart on the next page.
3. New drugs approved by the FDA that have not yet been reviewed by Express Scripts' Pharmacy and Therapeutics Committee will have a non-preferred status. AccessWV reserves the right to exclude a drug or technology from coverage until it has been proven effective.
4. Non-sedating antihistamines (Allegra®, Clarinex®, Zyrtec®). AccessWV will cover 34 days of therapy in a 180-day period. Therapy beyond 34 days requires prior authorization from RDT.
5. Tamiflu® and Relenza®. Coverage is limited to one course of treatment within 180 days. Additional quantities require prior authorization from RDT.
6. Toradol. Coverage is limited to one course of treatment (5 days) per 90-day period.

Generic name	Brand name	Quantity Limit Per Dispensing	Total Quantity Level Limit within a 28-Day Period
Almotriptan tablets 6.25 mg, 12.5 mg	Axert® - Pharmacia	6 tablets	18 tablets
Dihydroergotamine nasal spray	Migranal® - Novartis	4 spray devices	2 kits = 8 unit dose sprays
Eletriptan tablets 20mg, 40mg	Relpax® - Pfizer	6 tablets	18 tablets
Frovatriptan tablets 2.5 mg	Frova® - ELAN	9 tablets	27 tablets
Naratriptan tablets 1 mg, 2.5 mg	Amerge® - GSK	9 tablets	18 tablets
Rizatriptan tablets 5 mg, 10 mg, orally disintegrating tablets	Maxalt-MLT® - Merck	6 tablets	24 tablets
Rizatriptan tablets 5 mg, 10 mg	Maxalt® - Merck	6 tablets	24 tablets
Sumatriptan injection syringes	Imitrex® - GSK	1 kit (2 syringes)	8 kits = 16 injections
Sumatriptan injection vials	Imitrex®- GSK	2 vials	16 vials
Sumatriptan nasal spray 20 mg	Imitrex®- GSK	6 spray devices	3 boxes = 18 unit dose spray devices
Sumatriptan nasal spray 5 mg	Imitrex® - GSK	6 spray devices	6 boxes = 36 unit dose spray devices
Sumatriptan tablets 25 mg, 50 mg, 100 mg	Imitrex®- GSK	9 tablets	18 tablets
Zolmitriptan tablets 2.5 mg, 5 mg, orally disintegrating tablets	Zomig-ZMT® - AstraZeneca	6 tablets for 2.5 mg 3 tablets for 5 mg	18 tablets
Zolmitriptan tablets 2.5 mg, 5 mg	Zomig® - AstraZeneca	6 tablets for 2.5 mg 3 tablets for 5 mg	18 tablet

MAINTENANCE MEDICATIONS

You may receive up to a 90-day supply of the following medications and classes listed below. Only the medications on this list are available in 90-day supplies:

1. alendronate sodium (Fosamax®)
2. antiarthritics
3. anticoagulants
4. anticonvulsants
5. antidementia drugs
6. antihypertensives
7. antiparkinsonism agents
8. antispasmodics: urinary tract
9. benign prostatic hypertrophy/micturation
10. bronchodilators
11. calcitonin (Miacalcin®)
12. cardiovascular agents
13. cholinergic stimulants (urinary retention)
14. corticosteroids, bronchial
15. cromolyn sodium (Intal®)
16. diabetic therapies
17. digestants
18. disposable needles and syringes
19. diuretics
20. enzymes, systemic
21. estrogens and progestins
22. gastrointestinal, colitis
23. glaucoma agents
24. gout medications
25. hormones, misc.
26. immunosuppressive agents
27. legend vitamins (including legend hematinics, vitamin K)
28. leukotriene receptor antagonists (asthma agents)
29. lipotropics (cholesterol lowering agents)
30. mucolytics (pulmonary agents)
31. oral contraceptives
32. legend potassium
33. raloxifene (Evista®)
34. risedronate (Actonel®)
35. selective serotonin reuptake inhibitors (antidepressants in this class only)
36. thyroid medications
37. tuberculosis medications
38. xanthines (asthma agents)

COMMON SPECIALTY MEDICATIONS

AccessWV uses CuraScript as the exclusive pharmacy for common specialty medications. This means you will only be able to purchase these specialty medications through CuraScript, and the medication will be mailed to either your home or physician's office. Most often these are self-administered injections. After you have met your prescription drug deductible, the copay will be $50 for any medications in this class.

Please refer to the list of the most "Common Specialty Medications" on the next page. These drugs are not available in 90-day supplies.

In addition to providing these specialty medications to our members, CuraScript offers:

- A Patient Care Coordinator who serves as your personal advocate and point of contact.
- Delivery of your specialty medications directly to you or your doctor.
- Supplies to administer your medications — at no additional cost.
- Care management programs to help you get the most from your medications.

If you are prescribed one of these common specialty medications, call CuraScript toll-free at 1-866-413-4135 (8 a.m. – 9 p.m., Eastern time, Monday-Friday and 9 a.m. – 1 p.m., Eastern time, Saturday). A Patient Care Coordinator will contact your physician and work with you to schedule a delivery time for the medication.

Drug Name	Category
Acthar	Multiple Sclerosis
Aldurazyme	Mucopolysacchardosis
Aranesp [PA]	Anemia
Arixtra	Anti-Coagulant
Avonex	Multiple Sclerosis
Betaseron	Multiple Sclerosis
Bicillin C-R	Anti-Infectives
Botox [PA]	Migraine, Cerebral Palsy
Cerezyme	Gaucher Disease
Copaxone	Multiple Sclerosis
Copegus	Hepatitis C
Desferal	Diagnostic
Enbrel [ST]	Rheumatoid Arthritis
Epogen [PA]	Anemia
Fabrazyme	Fabry Disease
Fortaz	Anti-Infectives
Forteo [PA]	Osteoporosis
Fragmin	Anti-Coagulant
Fuzeon	HIV
Genotropin [PA]	Growth Hormone
Geref [PA]	Growth Hormone
Gleevec	Anti-Neoplastic
Humatrope [PA]	Growth Hormone
Humira [ST]	Rheumatoid Arthritis
Infergen	Hepatitis C
Innohep	Anti-Coagulant
Intron A	Interferons
Iressa	Anti-Neoplastic
Kineret [ST]	Rheumatoid Arthritis
Leukine	Hematopoietic
Leuprolide [PA]	Anti-Neoplastic
Lovenox	Anti-Coagulan

Drug Name	Category
Lupron [PA]	Anti-Neoplastic
Lupron Depot [PA]	Endometriosis, Anti-Neoplastic, Precocious Puberty
Myobloc [PA]	Neurologic
Neulasta	Neutropenia
Neumega	Hematopoietic
Neupogen	Neutropenia
Norditropin [PA]	Growth Hormone
Nutropin [PA]	Growth Hormone
Pegasys	Hepatitis C
Peg-Intron	Hepatitis C
Procrit [PA]	Anemia
Protropin [PA]	Growth Hormone
Pulmozyme	Cystic Fibrosis
Rebetol	Hepatitis C
Rebetron	Hepatitis C
Rebif	Multiple Sclerosis
Ribavirin	Hepatitis C
Rimso-50	Anti-Neoplastic
Rocephin	Anti-Infectives
Roferon-A	Anti-Neoplastic
Saizen [PA]	Growth Hormone
Sensipar	Hyperparathyroidism
Serostim [PA]	Growth Hormone
Tarceva	Anti-Neoplastic
Temodar	Anti-Neoplastic
Tev-Tropin [PA]	Growth Hormone
Thalomid	Anti-Neoplastic
Thyrogen Kit	Diagnostic
Tobi	Cystic Fibrosis
Xeloda	Anti-Neoplastic
Zavesca	Gaucher Disease
Zorbtive [PA]	Growth Hormone

DIABETES MANAGEMENT

- Blood Glucose Monitors: Covered diabetic insureds can receive a free Bayer Ascensia Elite®, Ascensia Elite® XL, Ascensia DEX2®, Ascensia Breeze® or Ascensia Contour® blood glucose monitor with a current prescription. Simply ask your pharmacist, and he or she will contact Bayer by fax or mail to request the monitor.
- Glucose Test Strips: The plan covers only Bayer Ascensia Elite®, Ascensia® Autodisc, or Ascensia® Microfill test strips at the preferred copay of $15 per 34-day supply. Other brands require a 100% copay.

- Needles/Syringes and Lancets: You can obtain a supply of disposable needles/syringes and lancets for the copays listed below:

Coverage	Needles/Syringes	Lancets
At the retail pharmacy:		
Up to a 34-day supply	$10	$5
35- to 68-day supply	$20	$10
69- to 90-day supply	$30	$15
Through the mail service and retail maintenance network pharmacies:		
Up to a 34-day supply	$10	$5
35- to 90-day supply	$20	$10

DRUGS OR SERVICES THAT ARE NOT COVERED

AccessWV does not cover the following medications or services:

1. Anorexients (any drug used for the purpose of weight loss)
2. Anti-wrinkle agents (e.g., Renova®)
3. Birth control drugs for dependent children
4. Bleaching agents (e.g., Eldopaque®, Eldoquin Forte®, Melanex®, Nuquin®, Solaquin®)
5. Charges for the administration or injection of any drug
6. Contraceptive devices and implants
7. Drugs dispensed by a hospital, clinic or physician's office
8. Drugs labeled "Caution-limited by federal law to investigational use," or experimental drugs not approved by the FDA, even though a charge is made to the individual
9. Drugs prescribed for uses not approved by the FDA
10. Drugs requiring a prescription by state law, but not by federal law (state controlled)
11. Erectile dysfunction medications
12. Fertility drugs
13. Fioricet® with Codeine
14. Fiorinal® with Codeine
15. Hair growth stimulants
16. Homeopathic medications
17. Immunizations, biological sera, blood or blood products, Hyalgan®, Synvisc®, Remicade®, Synagis®, Xolair®, Amevive®, Raptiva® (these are covered under the medical plan)
18. Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a hospital, sanitarium, or extended care facility
19. Medication for which the cost is recoverable under any Workers' Compensation or occupational disease law, or any State or governmental agency, or medication furnished by any other Drug or Medical Service for which no charge is made to the member
20. Non-legend drugs (except when included in a compound with a legend drug)
21. Pentazocine/Acetaminophen (Talacen®)
22. Prescription drug charges not filed within 6 months of the purchase date, if AccessWV is the primary insurer, or within 6 months of the processing date on the Explanation of Benefits (EOB) from the other plan, if AccessWV is secondary
23. Replacement medications for lost or stolen drugs
24. Requests for more than a 90-day supply of maintenance medications, or requests for more than a 34-day supply of short-term medications
25. Stadol® Nasal Spray
26. Therapeutic devices or appliances, including support garments and other non-medicinal substances, regardless of intended use, except those listed above
27. Vacation supplies, unless leaving the country

OTHER IMPORTANT FEATURES OF YOUR PRESCRIPTION DRUG PROGRAM

Your prescription drug program is designed to provide the care and service you expect, whether it's keeping a record of your medication history, providing toll-free access to a registered pharmacist, or keeping you in touch with any changes to your program.

Express Scripts uses the health and prescription information about you and your dependents to administer your benefits. They also use information and prescription data from claims submitted nationwide for reporting and analysis without identifying individual patients.

When your prescriptions are filled at one of Express Scripts' mail service pharmacies or at a participating retail pharmacy, pharmacists use the health and prescription information on file for you to consider many important clinical factors including drug selection, dosing, interactions, duration of therapy and allergies. Express Scripts' pharmacists may also use information received from your network retail pharmacy.

Drug Utilization Review

Under the drug utilization review program, prescriptions filled through the mail service pharmacy and participating retail pharmacies are examined by Express Scripts for potential drug interactions based on your personal medication profile. The drug utilization review is especially important if you or your covered dependents take many different medications or see more than one doctor. If there is a question about your prescription, your pharmacist may notify your doctor before dispensing the medication.

Education and Safety

You will receive information about critical topics like drug interactions and possible side effects with every new prescription Express Scripts mails. Your retail pharmacy may also provide you with drug information. By visiting www.express-scripts.com, you also can access other health-related information. Click on Drug Information or Health Information to browse information relative to specific health interests, get safety tips and answers to the most commonly asked medication questions, or just keep up with timely health issues. To view health information personalized to fit your interests, register with www.express-scripts.com. Any written health information cannot replace the expertise and advice of health care practitioners who have direct contact with a patient. All Express Scripts health information is designed to help you communicate more effectively with your doctor and, as a result, understand more completely your situation and choices.

Health Management

Based on your prescription and health information, Express Scripts may provide information to you on one or more of Express Scripts' Care Management programs, provided as a service to you by AccessWV. Program members generally receive educational mailings and may receive a follow-up call from an Express Scripts pharmacist or nurse. Express Scripts develops these programs to support your doctor's care, and they may contact your doctor regarding your participation in these programs.

Coordination of Benefits

If another insurance carrier is the primary insurer for a policyholder or a dependent, AccessWV will pursue coordination of benefits.

Commercial Insurance: As a secondary payor, AccessWV will pay only if the other insurance plan's benefit is less than what AccessWV would have provided as the primary insurer. If AccessWV is the secondary insurer, you must submit the following documentation to Express Scripts to have the secondary claim processed:

1. a completed Express Scripts claim form;
2. the receipt from the pharmacy; and
3. an Explanation of Benefits from the primary plan or a pharmacy printout that shows the amount paid by the primary plan.

You will usually be reimbursed within 21 days from receipt of your claim form. If you need claims forms, call Express Scripts' Member Services at 1-877-256-4680 or visit their website at www.express-scripts.com.

How to File a Claim

FILING A MEDICAL CLAIM

Medical claims are processed by Acordia National and should be submitted to:

Acordia National
P.O. Box 2451
Charleston, WV 25329-2451

This post office box should be used only for AccessWV claims. Please do not submit AccessWV claims to other Acordia post office boxes. This will only delay their processing. To process a medical claim, Acordia requires a complete itemization of charges including:

1. the patient's name;
2. the nature of the illness or injury;
3. date(s) of service;
4. type of service(s);
5. charge for each service;
6. diagnosis and procedure codes;
7. identification number of the provider; and
8. Social Security Number of the policyholder.

If the necessary information is printed on your itemized bill, you do not need to use an AccessWV claim form to submit your charges. Cash register receipts and canceled checks are not acceptable proof of your claim. If you have other insurance which is primary, you need to submit an Explanation of Benefits (EOB) from the other insurance with each claim, or ask your provider to do so if the claim is being submitted for you. You have six (6) months from the date of service to file a medical claim. If AccessWV is your secondary insurer, you have six (6) months from the date of your primary insurer's Explanation of Benefits processing date to file your claim with AccessWV. If you do not submit claims within this period, they will not be paid, and you will be responsible for payment to the provider. If your claim is for an illness or injury wrongfully or negligently caused by someone else, and you expect to be reimbursed by another party or insurance plan, you must file a claim with AccessWV within six (6) months of the date of service to ensure that the covered services will be paid. Later, if you receive payment for the expenses, you will have to repay the amount you received from AccessWV. See "Subrogation" on page 56 for details.

Claims Incurred Outside of the U.S.A.

If you or a covered dependent incur emergency medical expenses while outside the United States, you may be required to pay the provider yourself. Request an itemized bill containing all the information listed above from your provider and submit the bill along with a claim form to Acordia or Express Scripts. Acordia or Express Scripts will determine, through a local banking institution, the currency exchange rate and you will be reimbursed according to the terms of AccessWV.

Appealing a Claim

If you think that an error has been made in processing your claim or reviewing a service, the first step is to call Acordia (for medical claims) or Express Scripts (for pharmacy claims) to verify that a mistake has been made. All appeals must be initiated within 60 days of claim payment or denial.

Type of Error	Where to Call	Where to Write
Medical claim denial, out-of-state care denial, precertification or case management	Acordia National 1-866-864-6142	Acordia National P. O. Box 2451 Charleston, WV 25329-2451
Prior Authorization error or denial	RDT 1-800-847-3859	Rational Drug Therapy Program WVU School of Pharmacy PO BOX 9511 HSCN Morgantown, WV 26506
Prescription drug claim payment error or denial	Express Scripts 1-877-256-4680	Express Scripts, Inc. Clinical Appeals - (Client-WVA) BL0390 6625 W. 78th Street Bloomington, MN 55439

If your claim or service has been denied, or if you disagree with the determination made by Acordia National, Express Scripts, RDT or CuraScript, the second step is to appeal in writing within 60 days of the denial to Acordia National, Express Scripts, RDT or CuraScript.

Explain what you think the problem is, and why you disagree with the decision. They will respond to you by reprocessing the claim and/or sending you a letter with their response. If this does not resolve the issue, the third step is to appeal in writing to the Executive Director of AccessWV. The member, provider or covered dependent must request a review in writing within sixty (60) days of getting the decision from Acordia National, Express Scripts, RDT or CuraScript. Facts, issues, comments, letters, Explanations of Benefits (EOBs), and all pertinent information about the case should be included.

This third step appeal should be mailed to:

Executive Director: AccessWV
1124 Smith Street
P.O. Box 50540
Charleston, WV 25305-0540

When your request for review arrives, AccessWV will reconsider the entire case, taking into account any additional materials which have been provided. A decision, in writing, explaining the reason for modifying or upholding the original disposition of the claim will be sent to the member or his or her authorized representative.

If additional information is required to render a decision, this information will be requested in writing. The additional information must be received within 60 days of the date of the letter. If the additional information is not received, the case will be closed.

Other Information

PROHIBITION OF BALANCE BILLING

Any West Virginia health care provider who treats an AccessWV member must accept assignment of benefits and cannot balance bill the member for any portion of charges over and above the PEIA fee allowance or for any discount amount applied to a provider's charge or payment. This is known as the "prohibition of balance billing." The prohibition of balance billing applies when services are provided in West Virginia. Remember, you are always responsible for deductibles, copays, coinsurance amounts and non-covered services.

NEW TECHNOLOGIES

Upon FDA approval of a new technology, AccessWV determines whether or not to cover the item, service or procedure. These new technologies may or may not be covered. AccessWV often waits until the new technology proves effective before approving coverage. If you have concerns about coverage of a new technology, contact Acordia National for details.

PATIENT AUDIT PROGRAM

The Patient Audit Program offers rewards when you help detect and correct mistakes on your health care bills. Examine your medical bills for these two types of mistakes:

- Charges for services not received; and
- Overcharges or overpayments resulting from clerical error or miscalculation.

Reported errors must be at least $50.00 to qualify for the Patient Audit Program and must be submitted within 60 days of the processing date on the Explanation of Benefits (EOB). Complete the Patient Audit Report Form from PEIA and submit it, along with an itemized bill from the provider, the corrected bill (or explanation of disagreement), and a copy of the EOB, to PEIA.
PEIA, Acordia National or Express Scripts will investigate and recover the overpayment, if justified, from the provider of services. When the overpayment is processed you will be paid 50% of the recovered amount, up to $1,000 per plan year.

COORDINATION OF BENEFITS

In its effort to control health care costs, AccessWV has a coordination of benefits (COB) provision. Under this provision, when a person covered by AccessWV also has coverage under another policy (or policies), there are certain rules determining which policy is required to pay benefits first. The policy paying first is called the primary plan, and any other applicable policy is called the secondary plan. PEIA, on AccessWV's behalf, will request information about other coverage using a questionnaire mailed to the policyholder periodically. If the policyholder fails to respond to the questionnaire, claims will be denied until the information is received.

If you have health insurance coverage in addition to the AccessWV Plan, it is important to understand how the coordination of benefits provision works. AccessWV will be the secondary plan. Commonly under these circumstances, AccessWV will pay little or nothing of the balance of your medical bill.

If, after reviewing this section, you have questions concerning how AccessWV's coordination of benefits provision may affect you, contact an AccessWV Customer Service at 1-888-680-7342 extension 207 or 228.

Coordinating AccessWV Benefits with Other Plans

AccessWV is the payer of last resort of benefits whenever any other benefit or source of third-party payment is available. Benefits otherwise payable under plan coverage shall be reduced by all amounts paid or payable:

- Through any other insurance coverage.
- By all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment or liability insurance, whether provided on the basis of fault or nonfault.
- By any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program.

How Coordination of Benefits Works

When a claim is made, the primary plan pays its benefits without regard to any other plans. Then the secondary plan pays its benefits, adjusting for the benefits paid by the primary plan. The amount that AccessWV will pay as a secondary plan depends on what the primary plan pays. To calculate the amount AccessWV will pay as a secondary plan, you subtract the amount your primary plan pays from the amount AccessWV would have paid if there were no other insurance. If the other plan paid as much as or more than AccessWV would have paid as the primary plan, then AccessWV will pay nothing as the secondary plan. If the other plan paid less than AccessWV, then AccessWV will pay the difference up to what it would have paid had there been no other insurance.

RECOVERY OF INCORRECT PAYMENTS

If AccessWV or Acordia National discovers that a claim has been incorrectly paid, or that the charges were excessive or for non-covered services, Acordia National has the right to recover the payments from any person or any entity. You must cooperate fully to help recover any such payment. AccessWV will deduct overpayments from a provider's check to recover incorrect payments. This provision shall not limit any other remedy provided by law.

SUBROGATION AND REIMBURSEMENT

AccessWV may pay medical expenses on a member's behalf in those situations where an injury, sickness, disease or disability is caused in whole or in part by, or results from, the acts or omissions of a third party, or from the acts or omissions of an AccessWV member where other insurance (such as auto or homeowner's) is available. As a condition of receiving such expenses, AccessWV and its agents have the right to recover the cost of such medical expenses from the responsible party directly (whether an unrelated third party or another covered member) or from the member, if they have already been reimbursed by another. This right is known as subrogation.

AccessWV is legally subrogated to its member as against the legally responsible party, but only to the extent of the medical expenses paid on the member's behalf by AccessWV attributable to such sickness, injury, disease, or disability. AccessWV has the right to seek repayment of expenses from, among others, the party that caused the illness or injury, his or her liability carrier or the AccessWV member's own auto insurance carrier in cases of uninsured or underinsured motorist coverage, or medical pay provisions. Subrogation applies, but is not limited, to the following circumstances:

a) payments made directly by the person who is liable for an AccessWV member's sickness, injury, disease or disability, or any insurance company which pays on behalf of that person, or any other payments on his or her behalf;
b) any payments, settlements, judgments, or arbitration awards paid by any insurance company under an uninsured or underinsured motorist policy or medical pay provisions on the member's behalf; and
c) any payments from any source designed or intended to compensate an AccessWV member for sickness, injury, disease, or disability sustained as the result of the negligence or wrongful action or alleged negligence or wrongful action of another person.

It is the obligation of the AccessWV member to:

a) notify AccessWV in writing of any injury, sickness, disease or disability for which AccessWV has paid medical expenses on behalf of an AccessWV member that may be attributable to the wrongful or negligent acts of another person;
b) notify AccessWV in writing if the member retains services of an attorney, and of any demand made or lawsuit filed on behalf of an AccessWV member, and of any offer, proposed settlement, accepted settlement, judgment, or arbitration award;
c) provide AccessWV or its agents with information it requests concerning circumstances that may involve subrogation, provide any reasonable assistance requested in assimilating such information, and cooperate with AccessWV or its agents in defining, verifying or protecting its rights of subrogation and reimbursement; and

d) promptly reimburse AccessWV for benefits paid on behalf of an AccessWV member attributable to the sickness, injury, disease, or disability, once he or she has obtained money through settlement, judgment, award, or other payment.

Failure to comply with any of these requirements may result in:

a. AccessWV withholding payment of further benefits; and
b. An obligation by the AccessWV member to pay costs, attorneys' fees and other expenses incurred by AccessWV in obtaining the required information or reimbursement.

By acceptance of benefits paid under the plan, the AccessWV member agrees that AccessWV's rights of subrogation and reimbursement shall have a priority lien and the right of first recovery against any settlement or judgment obtained by or on behalf of a member. This right shall exist without regard to allocation or designation of the recovery.

These provisions shall not limit any other remedy provided by law. This right of subrogation shall apply without regard to the location of the event that led to or caused the applicable sickness, injury, disease or disability.

Please note: As with any claim, the claims resulting from an accident or other incident which may involve subrogation should be submitted within AccessWV's timely filing requirement of six (6) months. It is not necessary that any settlement, judgment, award, or other payment from a third party have been reached or received before filing a claim with AccessWV.

AMENDING THE BENEFIT PLAN

The benefits, premiums cost-sharing and other plan details will be reviewed at least annually by AccessWV's Board of Directors. Notice of any changes will be conveyed to members at least 30 days prior to their implementation.

AccessWV reserves the right to amend all or any portion of this Policy in order to reflect changes required by court decisions, legislation, actions by the Board, actions by the Executive Director or for any other matters as are appropriate. The Policy will be amended within a reasonable time of any such actions.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Summary

In order to provide you with benefits, AccessWV will receive personal information about your health from you, your physicians, hospitals, and others who provide you with health care services.

We are required to keep this information confidential. This notice of our privacy practices is intended to inform you of the ways we may use your information and the occasions on which we may disclose this information to others. Occasionally, we may use members' information when providing treatment. We use members' health information to provide benefits, including making claims payments and providing customer service. We disclose members' information to health care providers to assist them in providing you with treatment or to help them receive payment, we may disclose information to other insurance companies as necessary to receive payment, we may use the information within our organization to evaluate quality and improve health care operations, and we may make other uses and disclosures of members' information as required by law or as permitted by AccessWV policies.

Kinds of Information to Which This Notice Applies

This notice applies to any information in our possession that would allow someone to identify you and learn something about your health. It does not apply to information that contains nothing that could reasonably be used to identify you.

Who Must Abide by This Notice

- AccessWV
- All policyholders, staff, students, volunteers and other personnel whose work is under the direct control of AccessWV

The people and organizations to whom this notice applies (referred to as "we," "our," and "us") have agreed to abide by its terms. We may share your information with each other for purposes of treatment, and as necessary for payment and operations activities as described below.

Our Legal Duties

- We are required by law to maintain the privacy of your health information.
- We are required to provide this notice of our privacy practices and legal duties regarding health information to anyone who asks for it.
- We are required to abide by the terms of this notice until we officially adopt a new notice.

How We May Use or Disclose Your Health Information

We may use your health information, or disclose it to others, for a number of different reasons. This notice describes these reasons. For each reason, we have written a brief explanation. We also provide some

examples. These examples do not include all of the specific ways we may use or disclose your information. But any time we use your information, or disclose it to someone else, it will fit one of the reasons listed below.

1. Treatment. We may use your health information to provide you with medical care and services. This means that our policyholders, staff, students, volunteers and others whose work is under our direct control may read your health information to learn about your medical condition and use it to help you make decisions about your care. We will also disclose your information to others to provide you with options for medical treatment or services. For instance, we may use health information to identify members with certain chronic illnesses, and send information to them or to their doctors regarding treatment alternatives.

2. Payment. We will use your health information, and disclose it to others, as necessary to make payment for the health care services you receive. For instance, our customer service department or claims processing administrator may use your health information to help pay your claims. And we may send information about you and your claim payments to the doctor or hospital that provided you with the health care services. We will also send you information about claims we pay and claims we do not pay (called an "explanation of benefits"). The explanation of benefits will include information about claims we receive for the policyholder and each dependent who are enrolled together under a single contract or identification number. Under certain circumstances, you may receive this information confidentially: see the "Confidential Communication" section in this notice. We may also disclose some of your health information to companies with whom we contract for payment-related services. For instance, if you owe us money, we may give information about you to a collection company with which we contract to collect bills for us. We will not use or disclose more information for payment purposes than is necessary.

3. Health Care Operations. We may use your health information for activities that are necessary to operate this organization. This includes reading your health information to review the performance of our staff. We may also use your information and the information of other members to plan what services we need to provide, expand, or reduce. We may also provide health information to students who are authorized to receive training here. We may disclose your health information as necessary to others with whom we contract to provide administrative services or health care coverage. This includes our administrative services partner (PEIA), and its third-party administrators, lawyers, auditors, accreditation services, and consultants, for instance.

4. Legal Requirement to Disclose Information. We will disclose your information when we are required by law to do so. This includes reporting information to government agencies that have the legal responsibility to monitor the state health care system. For instance, we may be required to disclose your health information, and the information of others, if we are audited by state auditors. We will also disclose your health information when we are required to do so by a court order or other judicial or administrative process.

5. Public Health Activities. We will disclose your health information when required to do so for public health purposes. This includes reporting certain diseases, births, deaths, and reactions to certain medications. It may also include notifying people who have been exposed to a disease.

6. To Report Abuse. We may disclose your health information when the information relates to a victim of abuse, neglect or domestic violence. We will make this report only in accordance with laws that require or allow such reporting, or with your permission.

7. Law Enforcement. We may disclose your health information for law enforcement purposes. This includes providing information to help locate a suspect, fugitive, material witness or missing person, or in connection with suspected criminal activity. We must also disclose your health information to a federal agency investigating our compliance with federal privacy regulations.

8. Specialized Purposes. We may disclose the health information of members of the armed forces as authorized by military command authorities. We may disclose your health information for a number of other specialized purposes. We will only disclose as much information as is necessary for the purpose. For instance, we may disclose your information to coroners, medical examiners and funeral directors; to organ procurement organizations (for organ, eye, or tissue donation); or for national security, intelligence, and protection of the president. We also may disclose health information about an inmate to a correctional institution or to law enforcement officials, to provide the inmate with health care, to protect the health and safety of the inmate and others, and for the safety, administration, and maintenance of the correctional institution.

9. To Avert a Serious Threat. We may disclose your health information if we decide that the disclosure is necessary to prevent serious harm to the public or to an individual. The disclosure will only be made to someone who is able to prevent or reduce the threat.

10. Family and Friends. We may disclose your health information to a member of your family or to someone else who is involved in your medical care or payment for care. This may include telling a family member about the status of a claim, or what benefits you are eligible to receive. In the event of a disaster, we may provide information about you to a disaster relief organization so they can notify your family of your condition and location. We will not disclose your information to family or friends if you object.

11. Research. We may disclose your health information in connection with medical research projects. Federal rules govern any disclosure of your health information for research purposes without your authorization.

12. Information to Members. We may use your health information to provide you with additional information. This may include sending newsletters or other information to your address. This may also include giving you information about treatment options, alternative settings for care, or other health-related options that we cover.

YOUR RIGHTS

1. Authorization. We may use or disclose your health information for any purpose that is listed in this notice without your written authorization. We will not use or disclose your health information for any other reason without your authorization. If you authorize us to use or disclose your health information in additional circumstances you have the right to revoke the authorization at any time. For information about how to authorize us to use or disclose your health information, or about how to revoke an authorization, contact the person listed under "Whom to Contact" at the end of this notice. You may not revoke an authorization for us to use and disclose your information to the extent that we have taken action in reliance on the authorization. If the authorization is to permit disclosure of your information to an insurance company, as a condition of obtaining coverage, other law may allow the insurer to continue to use your information to contest claims or your coverage, even after you have revoked the authorization.

2. Request Restrictions. You have the right to ask us to restrict how we use or disclose your health information. We will consider your request. But we are not required to agree. If we do agree, we will comply with the request unless the information is needed to provide you with emergency treatment. We cannot agree to restrict disclosures that are required by law.

3. Confidential Communication. If you believe that the disclosure of certain information could endanger you, you have the right to ask us to communicate with you at a special address or by a special means. For example, you may ask us to send explanations of benefits that contain your health information to a different address rather than to your home. Or you may ask us to speak to you personally on the telephone rather than sending your health information by mail. We will agree to any reasonable request.

4. Receive a Copy of Health Information. You have a right to inspect the health information about you that we have in our records, and to receive a copy of it. This right is limited to information about you that is kept in records that are used to make decisions about you. For instance, this includes claim and enrollment records. If you want to review or receive a copy of these records, you must make the request in writing. We may charge a fee for the cost of copying and mailing the records. To ask to inspect your records, or to receive a copy, contact the person listed under "Whom to Contact" at the end of this notice. We will respond to your request within 30 days. We may deny you access to certain information. If we do, we will give you the reason, in writing. We will also explain how you may appeal the decision.

5. Amend Health Information. You have the right to ask us to amend health information about you which you believe is not correct, or not complete. You must make this request in writing, and give us the reason you believe the information is not correct or complete. We will respond to your request in writing within 30 days. We may deny your request if we did not create the information, if it is not part of the records we use to make decisions about you, if the information is something you would not be permitted to inspect or copy, or if it is complete and accurate.

6. Accounting of Disclosures. You have a right to receive an accounting of certain disclosures of your information to others. This accounting will list the times we have given your health information to others. The list will include dates of the disclosures, the names of the people or organizations to whom the information was disclosed, a description of the information, and the reason. We will provide the first list of disclosures you request at no charge. We may charge you for any additional lists you request during the following 12 months. You must tell us the time period you want the list to cover. You may not request a time period longer than six years. Disclosures for the following reasons will not be included on the list: disclosures for treatment, payment, or health care operations; disclosures for national security purposes; disclosures to correctional or law enforcement personnel; disclosures that you have authorized; and disclosures made directly to you.

7. Paper Copy of this Privacy Notice. You have a right to receive a paper copy of this notice. If you have received this notice electronically, you may receive a paper copy by contacting the person listed under "Whom to Contact" at the end of this notice.

8. Complaints. You have a right to complain about our privacy practices, if you think your privacy has been violated. You may file your complaint with the person listed under "Whom to Contact" at the end of this notice. You may also file a complaint directly with the Region III, Office for Civil Rights, U.S. Department of Health and Human Services, 150 South Independence Mall West, Suite 372, Public Ledger Building, Philadelphia, PA 19106-9111. All complaints must be in writing. We will not take any retaliation against you if you file a complaint.

OUR RIGHT TO CHANGE THIS NOTICE

We reserve the right to change our privacy practices, as described in this notice, at any time. We reserve the right to apply these changes to any health information which we already have, as well as to health information we receive in the future. Before we make any change in the privacy practices described in this notice, we will write a new notice that includes the change. The new notice will include an effective date. We will mail the new notice to all policyholders within 60 days of the effective date.

Whom to Contact

Contact the person listed below:

1) For more information about this notice, or

2) For more information about our privacy policies, or

3) If you want to exercise any of your rights, as listed on this notice, or

4) If you want to request a copy of our current notice of privacy practices.

Privacy Officer
AccessWV
PO Box 50540
Charleston, WV 25305-0540
1-866-445-8491
1-304-558-8264

Copies of this notice are also available at the reception desk of the AccessWV office at 1124 Smith Street, Charleston, WV 25305-0540. This notice is also available on our web site: www.Accessw.org

WHERE TO CALL WITH QUESTIONS

Health Claims, Benefits, and Preauthorizations

Acordia National 1-866-864-6142 (toll-free) or on the web at www.acordianational.com

Precertification and Utilization Management

Acordia National 1-866-864-6142 (toll-free) or on the web at www.acordianational.com

Prescription Drug Benefits and Claims

Express Scripts 1-877-256-4680 (toll-free) or on the web at www.express-scripts.com

Subrogation and Recovery

Beacon Recovery Group 1-800-874-0500 (toll-free)

Eligibility

PEIA 1-304-558-7850 or 1-888-680-7342 ext. 228 or 207 (toll-free) or on the web at www.wvpeia.com

Third Level Claim Appeals

AccessWV 1-304-558-8264 or 1-866-334-8491 (toll-free) or on the web at www.accessw.org

AccessWV

1124 Smith Street
P.O. Box 50540
Charleston, WV 25305-0540

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